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A VETERAN PUBLIC HEALTH REFORMER PLANNING FOR AN NHS: ARTHUR NEWSHOLME AND THE DISCUSSIONS ON MEDICAL PROVISION IN INTERWAR BRITAIN

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Abstract: Reorganization of medical provision was a subject of continual discussion in interwar Britain. Of the various plans brought out during this period, this paper focuses on that elaborated by Sir Arthur Newsholme, who was the chief medical official of England's public health administration until 1919. Special attention is paid to Newsholme's views on how to establish a comprehensive public medical system by balancing it with current politico-administrative notions such as 'local self-government' and 'voluntarism'.

INTRODUCTION

In Britain, public medical services had developed to a certain extent by the 1920s. But these developments had been made in a rather uncoordinated fashion, and not everyone in need was yet guaranteed adequate health care.

Thus, during the interwar period, different plans for the future health care system were elaborated by various bodies and experts, based on the general recognition that health care provision was inadequate and irrational, and that some scheme for socialization of medicine should be organized. Those plans can be classified into three categories, according to their preference as to who or which service should be the core of the future system. ① The British Medical Association (BMA) envisaged socialization of medicine through a national insurance scheme in which general practitioners (GPs) should become the linchpin, extending the existing National Health Insurance (NHI) to cover more services and recipients.[1] ② The voluntary hospital world sought their own scheme for coordinated hospital provision, in which their status as 'voluntary' hospitals

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[1] J. Lewis, 'Providers, consumers, the state and the delivery of health-care services in twentieth-century Britain', in A. Wear, *Medicine in Society* (Cambridge, 1992), p. 332–3.

should be secured.[2] ③ A unified medical service under the local authorities also had many advocates, including Ministry of Health (MH) officials, local Medical Officers of Health (MOHs), and Fabian social reformers. One of the most radical advocates of a local-authority-based system was the Socialist Medical Association, which published a plan for a comprehensive, free, salaried medical service to be managed by the local authorities in 1933.[3]

Apart from plans presented by major organizations, this paper focuses on a private plan elaborated by Arthur Newsholme (1857–1943), a retired public health official. Newsholme had played an active part in health policy-making, at the local level, as MOH for Clapham and Brighton, 1884–1908, and then, at the national level, as Chief Medical Officer to the Local Government Board (LGB), 1908–1919. The LGB was an antecedent of the MH: it had been in charge of the supervision and promotion of local authorities' public health work until it was replaced by the newly created MH in 1919. In his retirement, Newsholme authored several books concerning public medical provision. Understandably in view of his administrative career, he advocated a local-authority-based medical system: his plan could be included in category ③ above.

By focusing on the views of Newsholme, who had started his administrative career in the 1880s, we can see how the development of public health policy from the Victorian period intersected with the growing tendency to argue for socialization of medical provision in the interwar period, which continued during wartime and eventually led up to the formation of the National Health Service (NHS) in 1948.

Criticizing the traditional interpretations that converged on the establishment of consensus in the making of the NHS, Charles Webster has pointed out the importance of looking not just at consensus but also at conflicts in the socialization of medicine.[4] Indeed, conflicts of views and interests persisted even among medical practitioners who broadly supported socialized medical provision. Dorothy Porter has noted in particular that medical experts in the public health service (medical officers in central government and local MOHs) had different interests from the rest of the medical profession. Unlike the latter who tended to dislike state intervention affecting their independence, the public health officials wanted to increase state control on the basis of preventive medicine, over private practice. From the early 20th century, in corporation with Fabian reformers such as the Webbs, they campaigned for a comprehensive medical system to be administered by the local authorities, so that all the health services could be put under the supervision of MOHs. Porter regards Newsholme as the most distinguished member of this campaign circle.[5] Newsholme's activities have been explored in detail

[2] B. Abel-Smith, *The Hospitals, 1800–1948: A Study in Social Administration in England and Wales* (London, 1963), pp. 405–17.

[3] F. Honigsbaum, *The Division in British Medicine* (London, 1979), p. 182.

[4] C. Webster, 'Conflict and consensus: explaining the British Health Service', *Twentieth Century British History*, 1 (1990), pp. 115–51, esp. p. 117.

[5] D. Porter, 'Enemies of the race: biologism, environmentalism, and public health in Edwardian England', *Victorian Studies*, 34 (1991), pp. 171–2; D. Porter, *Health, Civilization and the State* (London, 1999), p. 205.

by John Eyler.[6] Both Porter and Eyler have emphasized the public health officials' professional aspiration to promote preventive medicine by taking control of public medical provision.

In reviewing Newsholme's views, this paper draws attention not only to his professional aspiration but also to his general stance on policy innovation, about which the historians have not sufficiently discussed. From a professional point of view, Newsholme envisaged a comprehensive state medical system as an ultimate ideal. Meanwhile, a careful reading of his plan suggests that he was cautious of establishing such a system at once by means of central bureaucratic powers. There was a difference of views even among the advocates of a local-authority-based public medical system, over how drastically (or gradually) reforms should be proceeded with.

Newsholme's plan was elaborated on the basis of his experience as an administrator. We will provide a brief overview of his administrative career in the first section. The second section deals with his plans for the reorganization and socialization of medical provision, by looking closely at his book *Medicine and the State* published in 1933. Examining his views on the respective roles of the private, voluntary and government sectors and how the reorganization should be proceeded with, we will try to illuminate his advocacy of a public medical system to be organized by the local authorities. We will go on to discuss in the third section why he advocated that local authorities should be the main locus of health policy innovation.

1. NEWSHOLME AS A PUBLIC HEALTH ADMINISTRATOR

The nation-wide administrative machinery for public health, in which Newsholme worked, had been established under the provisions of the Local Government Act, 1871, and the Public Health Act, 1872, following the recommendations of the Royal Sanitary Commission, 1869–71. It operated through local authorities, with the LGB as the central supervising department. The LGB was expected to be a 'Central Authority, ... not to centralise administration, but ··· to set local life in motion.[7] Thus, it was assigned to urge, but not to coerce, local authorities to undertake public health reforms in an appropriate manner. At the local level, county borough or borough councils (in large towns) and urban or rural district councils (in the country) were designated as 'local sanitary authorities' and assigned to deal with public health problems, by employing an MOH. In proposing this administrative machinery, the Royal Commission was committed to the notion of local self-government, which was 'generally recognized as the essence' of England's national vigour, and as 'the distinguishing feature' of government in England. Thus, large discretion was left to local government: while required to fulfil basic duties, the local councils could decide, on the basis of local political consensus, to what extent public health policy should be implemented.[8]

[6] J. M. Eyler, *Sir Arthur Newsholme and State Medicine 1885–1935* (Cambridge, 1997).

[7] *Second Report of the Royal Sanitary Commission*, in Parliamentary Papers, 1871, XXXV, pp. 30–31.

[8] *Ibid.*, pp. 16, 69.

After several years of experience as a hospital junior doctor and GP, Newsholme entered this machinery as part-time MOH for the Metropolitan Borough of Clapham in 1884. In 1888 he was appointed the full-time MOH by Brighton [County] Borough Council. In 1908, he moved to the LGB and served as its Chief Medical Officer until the Board was absorbed into the new MH in 1919.

1.1. Newsholme in Brighton, 1888–1908

The twenty years Newsholme was in Brighton overlaps with the period during which MOHs became increasingly professional as practitioners of 'preventive medicine', as specialist knowledge of disease prevention increased due to developments in bacteriology and epidemiology, and due to their accumulation of practical experience in administrative work.[9] Under Newsholme's guidance, Brighton County Borough Council developed systems dealing with several varieties of individual patient, not just those suffering from highly communicable acute infection, but also unhealthy children and pulmonary tuberculosis (TB) patients. Thus, the scope of the local authority's work was no longer confined, as it had been, to improvement of the town's general sanitary environment, but extended into the sphere of personal service provision. Notably, Newsholme was a pioneer in initiating measures against TB, and this made him a leading member of the 'preventive' medical profession.

But the extent of the local authority's work at that time should not be overstated. The emphasis of its personal services was primarily on prevention, through ensuring proper isolation or giving instructions to patients and their families as to hygiene. A large share of responsibility was attached to patients themselves and their families. It was not intended that the local authority should embark on full-blown comprehensive health care provision on its own. Cooperation with private practitioners and voluntary organizations remained important. In particular, Newsholme tried to utilize voluntary efforts as far as possible.[10]

It should also be noted that Newsholme proceeded with these policy innovations gradually and partially, and within the boundaries that a majority on the local council could accept as an appropriate extent of government action. The MOH was an employee of the local council. From a political point of view, it was reasonable for him not to proceed too radically. This gradualism may be understood better by relating it to dominant notions of government and society at that time.

Pat Thane and Jose Harris have focused on the network of notions concerning the structure and working of government and society, which became dominant around the mid-Victorian period and, despite increasing challenge from the late 19th century, survived well into the first half of the 20th century. A central assumption underlying these notions was that the role of the state should be limited to providing a framework within

[9] E. Fee and D. Porter, 'Public health, preventive medicine and professionaliztion: England and America in the nineteenth century', in A. Wear (ed.), *Medicine in Society* (Cambridge, 1992), pp. 270–1.

[10] For a detailed account, T. Nagashima, 'Arthur Newsholme and English Public Health Administration 1888–1919', D. Phil. thesis, (University of Sussex, 2001), Chapters 1–3. See also Eyler, *Sir Arthur Newsholme*, Chapters 3–6.

which society could largely run itself. It was widely thought desirable that local citizens should voluntarily address local affairs through institutions of local government or through voluntary associations.[11] As has been pointed out above, while introducing uniformity and compulsion to some extent, the 1870s system of public health administration still largely assumed the notions of local self-government, and of voluntary involvement of local citizens. It would be time-consuming to build local consensus, by coordinating conflicting opinions and interests on the local council, and encouraging local people's voluntary cooperation, but such means of government were preferred to a highly centralizing, bureaucratic approach. In view of these notions that were still widely shared in the late 19th century, it is appropriate to see the political elements of the gradualism in Newsholme's policy innovation as a result of his effort to observe the current notions of government and society, rather than to reducing it merely to a matter of his personality and tactics.[12]

In the process of developing anti-TB measures in Brighton through the early 1900s, Newsholme became convinced that, in order to prevent poverty and sickness, it was desirable to expand free medical services, on the basis of preventive medicine, by unifying public health and poor law medical services under the control of local sanitary authorities. He became acquainted with Beatrice Webb, who was working for the Royal Commission on the Poor Laws 1905–09, and his idea influenced the famous Minority Report of the Commission which Beatrice and Sidney Webb authored. The Webbs urged the break-up of the Poor Law and, with regard to medical provision, they proposed to create a comprehensive public medical system by incorporating poor law medical services and voluntary medical services into the local authorities' jurisdiction, so that they could be organized on the basis of preventive medicine, free from stigma.[13]

Thus, Newsholme came to be counted as a member of the Webbs' alliance of professionals and civil servants supporting the Minority Report, of which Robert Morant (Secretary to the Board of Education, and later to the National Insurance Commission) and George Newman (MOH for Finsbury, later Chief Medical Officer to the Board of Education) were already members. It should be noted, however, that Newsholme, unlike the Webbs and their fellow campaigners, did not insist that the administrative reforms should be implemented all at once by means of strong central government initiatives. What he envisaged was that the reforms should come about partially, on a field-by-field basis (e.g. first, in the field of acute infection, then, that of TB, and so on), based on

[11] P. Thane, 'Government and society in England and Wales, 1750–1914'; J. Harris, 'Society and the state in twentieth century Britain', in F. M. L. Thompson (ed.), *The Cambridge Social History of Britain 1750–1950* (Cambridge, 1990), vol. 3, pp. 1–62, pp. 63–118.

[12] Eyler has connected Newsholme's gradualism, first, with the gradual evolution of medical ideas and epidemiological studies and, second, with his pragmatism as an administrator. I basically agree on these points. On the second point, however, Eyler has not extended his argument beyond Newsholme's shrewdness and expediency. Eyler, *Sir Arthur Newsholme*, pp. 142, 380.

[13] A. Newsholme, 'A discussion on the co-ordination of the public medical services', *British Medical Journal*, 1907, ii, pp. 656–60; S. and B. Webb, *English Poor Law History*, Part II (1929), p. 541.

local circumstances and local political consensus, just as he had actually attempted in Brighton.[14]

1.2. Newsholme at the LGB, 1908–1919

In 1908, Newsholme was singled out by John Burns, President of the LGB, for the Chief Medical Officer of his Board. There, Newsholme endeavoured to promote the formation of local authorities' schemes for socialized health provision in three particular fields: TB treatment, maternity and infant welfare, and venereal diseases (VD) treatment. During 1908–19, the LGB provided grant-in-aid to encourage local authorities to establish their own schemes for TB, maternity and infant welfare, and VD. Together with the provision of grant-in-aid, the LGB issued guidelines for the making of local schemes, which were elaborated by Newsholme in the light of the experiences of pioneering local authorities, including his own at Brighton.

The model range of measures indicated in the LGB's guidelines for local authorities covered a combination of clinic, health visiting, and institutional services. ① Dispensaries for TB, clinics for mothers and babies, and treatment centres for VD were designed to encourage people's access to medical advice. It was expected that early diagnosis and subsequent supervision by practitioners of preventive medicine over the clients would be secured. ② Home visiting was another means of securing contact between the clients and the public health workers. ③ Intensive care and supervision of serious cases were to be given at institutions. The guidelines indicated that the local authority should, in conjunction with local voluntary agencies, secure the provision of beds in TB sanatoria, hospitals for women and children, and VD treatment centres.[15]

While the LGB expanded its work under Newsholme's guidance, the basic structure of central-local relations was unchanged. All the services under the jurisdiction of the LGB were still organized and administered locally, and as ever the LGB's job was to supervise them.[16] While central intervention became intense in relation to the provision of grants-in-aid and to the wartime circumstances (the First World War, 1914–1918), this was not necessarily intended as a means to centralize administration, and a large share of decision-making was still left to the local authorities. The assumption, which had conventionally underlaid the relationship between the LGB and local authorities that the role of central government was to provide a framework of guidelines to enable the local community to make its own decisions was still largely in effect.

The LGB's gradual approach to policy innovation irritated those who wanted drastic changes by means of stronger bureaucratic initiatives, among others, Robert Morant

[14] See Newsholme's advice to Mrs. Webb about the need for a 'piece-by-piece' approach. 'Interview to Dr. Newsholme', December 22, 1906, in S. and B. Webb, Local Government Collection, vol. 335 (housed in the British Library of Political and Economic Science, the London School of Economics).

[15] LGB circular to county councils and sanitary authorities, 'Treatment of Tuberculosis', July 6, 1921; 'Maternity and Child Welfare', July 30, 1914; Memorandum by Newsholme, 'On the Organisation of Medical Measures against Venereal Diseases', May 1916, PRO. MH55/531. For a detailed account of each measure, see Eyler, *Sir Arthur Newsholme*, Chapters 9–11.

[16] For a recent account of the LGB, see C. Bellamy, *Administering Central-Local Relations 1871–1919: The Local Government Board in its Fiscal and Cultural Context* (Manchester, 1988).

and George Newman, who had been Newsholme's allies around the time of the Royal Commission on the Poor Laws. Despite their common ideal (i.e. a comprehensive public medical provision administered by local authorities), Morant and Newman came to distrust Newsholme, since Newsholme, at the LGB, tended to proceed with policy innovations only partially and slowly, in deference to local government, instead of acting decisively and shrewdly.[17] They felt it necessary to get rid of 'unimaginative' senior LGB officials, including Newsholme, and to establish a new, stronger central ministry. The outcome was the establishment of the MH in 1919, replacing the LGB, with Christopher Addison as Minister, Morant as Permanent Secretary and Newman as Chief Medical Officer. Newsholme and the LGB ended their official career together.[18]

2. NEWSHOLME'S PLAN FOR ORGANIZATION OF MEDICAL PROVISION

After his retirement, Newsholme elaborated his ideas as to what system of medical provision would be desirable and how it should be attained.[19] He succinctly described his plan in *Medicine and the State*, published in 1932.[20] His starting proposition was that 'the health of every individual is a social concern and responsibility' and, therefore, the community should provide free medical services for every one of its members, regardless of his or her means.[21] In the book, he discussed what forms of relationship between state and private medical practice would provide the best basis for implementing the proposition.

2.1. 'State medicine': the voluntary and government sectors

It should be noted that, in the phrase 'state medicine', Newsholme included not only

[17] George Newman, Diary, December 18, 1913, PRO. MH 139/2.

[18] Apart from the LGB, the new Ministry incorporated the National Insurace Commission which had administered the NHI. For classic accounts of the establishment of the MH, see B. B. Gilbert, *British Social Policy 1914–1939* (London, 1970), pp. 99–103; F. Honigsbaum, *The Struggle for the Ministry of Health* (London, 1970). These historians view the struggle for the MH mainly from the viewpoint of the champions of the new Ministry and, therefore, tend to see the LGB officials, including Newsholme, as timid and unimaginative. Recently, Newsholme has been defended sensibly by Eyler, who argues that, though Newsholme was an effective official, his actions were hindered by the LGB's departmental conservatism. Eyler, *Sir Arthur Newsholme*, pp. 316–37, 386–90. While agreeing on his point that Newsholme was effective, I am concerned that Eyler's stress on Newsholme's personal effectiveness might obscure merits of the LGB's gradual approach in policy innovation, which might have seemed 'tardy' but not only the 'unimaginative' LGB officials but also the 'effective' Newsholme advocated.

[19] Newsholme's publications in the 1920s include *Public Health and Insurance: American Addresses* (Baltimore, 1920); *The Ministry of Health* (London, 1925); *Health Problems in Organized Society: Studies in the Social Aspects of Public Health* (London, 1927).

[20] Eyler has explored Newsholme's plan for state medicine, focussing chiefly on his interaction with health reformers in the United States, where he visited several times in his retirement. Eyler, *Sir Arthur Newsholme*, Chapter 12. In reviewing Newsholme's views, this paper focuses on the consistency of his sympathetic attitude to traditional ideas of government and society in England, and with how it was expressed in his plan for state medicine, about which Eyler has not sufficiently discussed.

[21] A. Newsholme, *Medicine and the State: the Relation between the Private and Official practice of Medicine, with Special Reference to Public Health* (London, 1932), p. 29.

the medical activities of the government sector but also those of the voluntary sector. He termed both statutory and voluntary bodies 'public agencies'. Thus, in his terminology, 'state medicine' did not necessarily mean 'nationalized' or 'municipalized' medicine. He saw no essential difference between local councils and local voluntary bodies, both of which provided gratuitous services under the management of unpaid volunteers (councillors/governors), employing specialized workers.[22] It may be thought that his wish to establish a cooperative relationship between the local authorities and voluntary bodies, which he had tried to achieve at Brighton and at the LGB in relation to TB, VD, and maternity and child welfare, was reflected in this unique usage of the term.

In practice, however, there was still a lot to be resolved in order to consolidate cooperation between the government and voluntary sectors, especially in the area of hospital provision. Voluntary hospital provision continued to grow during the 1920s. Under financial uncertainty, some voluntary hospitals introduced new sources of funding, such as charges on patients, or subscriptions from patients through hospital contributory schemes. Many voluntary hospitals also received government subsidies in return for their cooperation in local TB, VD, or maternity and child welfare work. While voluntary hospitals were in need of government subsidy, they were worried about government intervention affecting the independence of their management. In the meantime, especially in larger towns, local authority hospitals, many of which were former poor law infirmaries, emerged as 'medical' institutions of some quality, concerned more with 'patients' and less with 'paupers'.[23] These local authority hospitals, now with little difference in quality and function, appeared to be a threat to voluntary hospitals.[24]

To Newsholme, however, the increasing resemblance between voluntary and local authority hospitals and the increasing financial dependence of the former on government subvention seemed to provide a chance to remove the division between the two sides. Both voluntary and local authority hospitals aimed at free provision of medical aid at community expense. Of course, there were still some differences. While local authority hospitals had to admit every case medically in need of hospital treatment, voluntary hospitals could select patients. While funds for the former were raised through taxation, those for the latter were raised still chiefly through charity. However, these differences were, in Newsholme's view, 'not essential, and under either a voluntary or an official organisation a good and adequate hospital service can be provided'.[25] In urging schemes for hospital provision locally, he suggested utilizing existing voluntary hospitals, as well as statutory hospitals, where it was possible:

[22] *Ibid.*, pp. 20, 23, 46.

[23] M. A. Crowther, *The Workhouse System 1834–1929: The History of an English Social Institution* (1981), p. 186. The transfer of Poor Law administration from the boards of guardians to the county and county borough councils was prescribed by the Local Government Act, 1929.

[24] S. Cherry, *Medical Services and the Hospitals in Britain 1860–1939* (Cambridge, 1996), pp. 60–3, 71–4.

[25] Newsholme, *Medicine and the State*, p. 107.

> In Great Britain no clear-cut decision as to the future of voluntary and official hospitals is possible. Nor is it desirable. In organising more efficient hospital provision one cannot start anew, but present provision must ... be utilised and extended as necessary ...[26]

It is important to note that Newsholme did not think that the statutory sector should compulsorily take over the voluntary sector, though he acknowledged the trend towards the former dominating over the latter, which was, in his view, inevitable in view of some technical advantages the state had, e.g. fund raising powers, and legal powers.[27]

2.2. Private practice and state medicine

Newsholme rejected the antithesis between state and private medical practice, saying that 'they can and do co-exist'.[28] The private GP, as family physician, was acknowledged to be 'the most important single agent engaged in medical work'. However, 'adequate medical care for a large proportion of the total number of sick persons necessitates the organisation of measures and of institutions beyond the power of the individual private medical practitioner to provide'.[29] Financially, the expense of private practice was increasingly becoming a burden for a large share of the population (not just the very poor).[30] Medically, it was difficult for GPs to cope all alone with specialization which was 'in spectacular progress'.[31] Thus, the necessity for state medicine, including not only environmental but personal services, was justified.

The extension of state medicine alarmed the BMA, which represented the interests of private practitioners.[32] According to Newsholme, however, so-called 'encroachments' of state medicine on private practice consisted 'chiefly of territory never previously occupied'.[33] In fact, Newsholme at the LGB tried to extend the scope of local authorities' work only to the spheres which, in his view, private practitioners had failed to occupy effectively, i.e. those of TB and VD treatment, maternity and infant welfare. He distinguished his idea from 'either of the schools of thought, represented by those who wish for a state system of medicine in the fullest sense, that is, a service worked by whole-time medical officers; or the body of general practitioners of medicine who wish to be left alone, who resent every additional so-called encroachment on their work'. [34]

[26] *Ibid.*, p. 101.

[27] He argued that, only when demerits of relying on the voluntary agency had been found to be conspicuous, the state (local authority) should take over its work. Newsholme, *Public Health and Insurance*, p. 142.

[28] Newsholme, *Medicine and the State*, p. 21.

[29] *Ibid.*, pp. 41–3.

[30] *Ibid.*, p. 54.

[31] *Ibid.*, p. 30. For a recent account of the relationship between general practice and specialization, see A. Digby, *The Evolution of British General Practice 1850–1948* (Oxford, 1999), pp. 287–305.

[32] J. Lewis, *What Price Community Medicine ?: The Philosophy, Practice and Politics of Public Health since 1919* (Brighton, 1986), pp. 18–26.

[33] Newsholme, *Medicine and the State*, p. 242.

[34] *Ibid.*, p. 23.

Thus, he advocated cooperative, rather than isolated, independence of state medicine and private practice.[35]

The relationship between state and private medical practice was also the subject of a plan submitted by Dr Bertrand Dawson. What were the similarities and differences between Newsholme's and Dawson's plans? The two had met at a meeting of the Royal Society of Medicine in April 1918. At this meeting, Newsholme pointed out the need for the coordination of preventive medicine with clinical medicine. He advocated organized medical provision in which 'there should be more team-work than in the past, both between the consultant and private practitioner, the nurse and doctor, and between unqualified and qualified persons'. Citing as illustrations the recent measures introduced by the LGB with regard to VD and infant welfare, he implied that the local authorities were the most suitable agencies for organizing local medical provision.

Bertrand Dawson, at the same meeting, agreed with Newsholme that curative and preventive medicine should come together, and that there should be some sort of state action to make medical provision available for a larger proportion of the population. However, he rejected the idea that the medical profession should become part of the civil service, because this, he thought, 'would kill all that was best in the profession'. It should be noted that the transfer of the entire profession to a salaried service was, as we have discussed, not necessarily what Newsholme intended. Therefore, on this point, Newsholme and Dawson could still agree. Like Newsholme, Dawson advocated the creation of an institution by the state to integrate curative services with preventive or special medicine, and private practice with publicly organized medical provision. But, unlike Newsholme, he envisaged private practitioners, not salaried officers, for the management of such institutions.[36]

Dawson was appointed chairman of the Consultative Council on Medical and Allied Services of the new MH in 1919. The Council's report ('the Dawson Report') was published in May 1920. It was basically a development of the ideas that Dawson had outlined at the Royal Society of Medicine. The term 'health centre' was employed for institutions bringing together curative and preventive services in a district. The private GP was expected to utilize its facilities and to cooperate with other GPs at the 'primary health centre', and with hospital consultants at the 'secondary health centre' where difficult or special cases found in his practice could be treated. The Report was supported by the BMA, since it assumed private GPs as the linchpin of the scheme.[37]

However, as Newsholme pointed out, the Report failed to relate its framework to the existing administrative machinery. In particular, little reference was made to the work of the local authorities, which, from Newsholme's point of view, 'must necessarily be incorporated and form a chief element in any more general medical service'.[38] Newsholme opposed the idea that private practitioners, not salaried officers, would manage

[35] *Ibid.*, p. 232.
[36] *Lancet*, 1918, i, pp. 572–3.
[37] *British Medical Journal*, 1920, i, pp. 800–2.
[38] Newsholme, *Medicine and the State*, pp. 104–5.

public medical schemes.[39] Partly due to the lack of concrete proposals on how to connect the health centres with the existing health activities, the Dawson Report had little impact on the MH's policy making. Newman, Chief Medical Officer, did not support it, as he, like Newsholme, advocated a unified medical service under the local public health authorities.[40]

Newsholme used the term 'socialization of medicine' to describe the process by which free medical provision could be made available to everyone in need at public expense. The provision of vaccination against smallpox was regarded as a classic example of complete socialization. Patients with acute infection were usually treated free in local authority hospitals. Thus, it was said that medicine was almost socialized with regard to acute infectious diseases.[41] Socialization was also under way through local authority clinics for TB and VD patients, mothers and babies. Newsholme thought it desirable to extend socialization to other areas of medical provision, since it was becoming increasingly difficult for a large section of the population to afford the cost of sickness. However, he denied the necessity for a drastic socialization of the entire medical provision, e.g. by replacing private practice with state medicine. What he thought necessary was 'the regularisation and partial extension of what already exists in inchoate forms'.[42] Thus, he envisaged partial, gradual socialization, by organizing local schemes, just like those he promoted at the LGB for TB, VD, and maternity and child welfare, involving the private, voluntary and government sectors in the community.

While Newsholme acknowledged the continuance of private practice, this meant that public 'encroachment' would not be confined to 'the territory never occupied', in the future. As the BMA feared, who would pay for private practice, while free, if partial, public medical provision was available? It would be impossible to achieve socialization in Newsholme's terms without affecting the conventional form of private practice. Indeed, he ultimately envisaged a system in which medical provision would normally be paid from public money, except that for the rich. However, a salaried service was not the only option he suggested, although it might have been his preference. He suggested a contract medical practice as another option, in which the private practitioner would be remunerated under contract with the organizer of socialized medicine.[43]

This method had already been adopted in the NHI system (established in 1911): 'panel' doctors received remuneration by contract. However, Newsholme was critical of the existing NHI system. This was mainly because, under the system, health insurance was organized by those who were not concerned with preventive medicine: 'approved societies'. While acknowledging the merit of health insurance *per se* as a form of collective action against health risks, he thought that the existing NHI, which was administered independently of public health authorities, was unsatisfactory. He was

[39] Eyler, *Sir Arthur Newsholme*, pp. 363–5.

[40] Lewis, *What Price Community Medicine?*, pp. 18–22; C. Webster, 'The Metamorphosis of Dawson of Penn', in D. and R. Porter (eds.), *Doctors, Politics and Society* (Amsterdam, 1993), pp. 218–9.

[41] Newsholme, *Medicine and the State*, p. 234.

[42] *Ibid.*, p. 256.

[43] *Ibid.*, pp. 244–55.

concerned that, under this system, benefits were provided virtually unconditionally with little effort to secure prevention. He suggested that a health insurance scheme should be incorporated into a more comprehensive scheme, to be organized not just for the insured but for the community as a whole, under the guidance of public health experts.[44] In fact, he had held this standpoint since he had been in Brighton: he seems always to have envisaged possibilities for the partial extension of public medical provision by incorporating existing health insurance activities.[45]

Newsholme advocated voluntary methods of raising money for socialized medicine, i.e. insurance and charity, as long as provision through such voluntary action was combined with the activities of local public health authorities. But, at the same time, he thought that, in view of the increasing difficulty of collecting voluntary contributions, it was inevitable that national or local taxation would be the chief financial source in any scheme for socialization of medicine.[46] In practice, however, the rise in health expenditure was becoming a burden to government finance at a time of economic stagnation.[47] With regard to the issue of cost and financing, Newsholme suggested little more than a simple, optimistic economics: 'Health is worth whatever cost is properly incurred in its maintenance or to secure its return'.[48] It seems that, as a 'medical' expert, he left the financial issue open.

3. NEWSHOLME'S ADVOCACY OF A LOCAL-AUTHORITY-BASED SYSTEM

Newsholme ultimately envisaged a comprehensively socialized public medical system. But we should not be preoccupied only with the advanced state-interventionist statements: otherwise, we are likely to overlook Newsholme's subtle balancing of his medical aspirations with his sympathy for established notions about the relationship between government and society. It is important to notice that, while urging the extension of public medical provision beyond 'the territory never occupied', he assumed that changes should come gradually and his ideas left room for private and voluntary medical providers to retain their status and to cooperate voluntarily with the public medical schemes. Why did he advocate such gradual socialization? Was this simply an expedient designed to compromise with opponents of state intervention?[49] Let us explore these questions by focussing on his advocacy of local authorities as the agent of gradual policy innovation.

[44] *Ibid.*, pp. 106–47. See also, Eyler, *Sir Arthur Newsholme*, pp. 227–38.

[45] Newsholme envisaged cooperation with friendly societies, in launching sanatorium provision for TB patients in Brighton. Brighton Medical Officer of Health, *Annual Report*, 1901, pp. 45–7; *Brighton Herald*, May 7, 1904. In view of this, Eyler's argument, that Newsholme changed his attitude to health insurance after his retirement, is confused. Eyler, *Sir Arthur Newsholme*, p. 355–8. It mixes Newsholme's view on health insurance per se with his criticism of the existing NHI system, and Newsholme's idealistic aspiration for a fully socialized, comprehensive state medical service, with his advocacy of partial, gradual socialization by means of incorporating health insurance at the local level.

[46] Newsholme, *Medicine and the State*, p. 266.

[47] P. Thane, *Foundations of the Welfare State*, 2nd edn.(1996), pp. 179–80.

[48] Newsholme, *Medicine and the State*, p. 59.

[49] Eyler tends to take this view. See Eyler, *Sir Arthur Newsholme*, pp. 363–4.

3.1. Advantages of the local authorities

Newsholme should be included among advocates of a unified service under the local authorities. However, his discussion in *Medicine and the State*, in which emphasis was placed on involvement of 'what already exists', obscured where exactly he stood. He did not provide a comprehensive, consistent plan for the coordination between the existing providers, with an exact definition of their roles. Extensions of both health insurance and salaried service were listed in parallel as options for socialization of medicine. Thus, many things remained open to further consideration.

It can be argued that this reflected Newsholme's standpoint. His plan should not be read as a complete one which could be implemented all at once by central government. The details of arrangements for coordination were left to further consideration in each locality. His intention was to give guidelines, rather than a single plan for a nationally uniform system of health care provision. This was partly because the availability of 'what already exists' varied locally. In addition, he thought it essential that a scheme for socialization of medicine should be based firmly on local needs and local consensus. The details of the scheme should be decided locally by agreement between all the parties concerned, not only those who delivered the services but also those who paid for and those who used them.

Thus, Newsholme did not urge the establishment of a comprehensive, free, salaried medical service at once, uniformly all over the country, according to a central plan. He insisted on the need for a co-existence between private and state medicine, instead of replacing the former with the latter: he expected the voluntary involvement of private practitioners. His version of 'state medicine' could be paraphrased as 'public' or 'communal medicine', and included not only statutory but also voluntary medical activities. It seems clear that he regarded voluntarism as an important element of communal action. Thus, in deference to voluntary organizations and private agencies' voluntary cooperation with communal activities, he envisaged gradual change towards his ideal, through the pursuit of partial arrangements between those agencies and the local public health authority.

As Porter and Eyler have pointed out, Newsholme persisted in the coordination of medical provision under the local public health authorities in order to avoid further complication in health administration, and to secure the penetration of preventive medicine under MOH supervision.[50] In addition, let us here pay special attention to his emphasis on the function of the local authorities as councils of local people. A local authority consisted of administrative departments led by salaried officials and a council of elected politicians which superintended the officers. In theory, therefore, local public opinion could be reflected in the making and management of the scheme for socialization of medicine, by putting it under a local authority. Thus, he saw advantage in local authorities not only from a viewpoint of preventive medicine but also from a political point of

[50] D. Watkins (now Porter), 'The English Revolution in Social Medicine', Ph. D. thesis (University of London, 1984), pp. 225–39; Eyler, *Sir Arthur Newsholme*, pp. 227–38.

view. This was his cherished view for long time. In 1909, he commented:

> Those who fear the extended rule of bureaucracy do not sufficiently realise that in British self-government, whether central or local, the elected amateur always has the controlling power, whether as Member of Parliament or as a member of local governing bodies. This British method, though occasionally irritating the expert, is in my view a satisfactory compromise.[51]

Since, in his view, a substantial portion of funds for thee socialization of medicine would inevitably come from local rates and Treasury grants (via the local authority), Newsholme thought it appropriate that the scheme be subject to 'a corresponding control by the representatives of the tax and ratepayers'.[52] Rate-payers themselves would be among users of the services under this scheme, which would be designed for the use not just of the poor but a larger section of the local population. The Representation of the People (Equal Franchise) Act, 1928, enabled all men and women (over 21) who were themselves, or were married to, occupiers of any property within the area to vote in local elections. Local councillors could represent the interests of most clients, though the very poor without means of occupying any property, who were the most likely clients of socialized medicine, were still left outside the franchise. Newsholme quoted the phrase of Stanley Baldwin, the Conservative Prime Minister who worked for the introduction of the 1928 Act: 'every unit in the community can be made to count'.[53]

All the advocates of a unified health system under local authority control more or less pointed out its 'democratic' merits. But what is characteristic of Newsholme is that he thought it desirable to make the most of the democratic functions not only in the management of the established system but in the making of it. Newsholme was aware that conflicts of interest would inevitably arise in establishing a public medical scheme. Such conflicts were to be settled at the local council. Not only clients but also local medical providers could in theory express their views to the council. This might be time-consuming, but Newsholme thought it important to proceed with extensions of public health-care provision gradually through coordination of interests at the local council. Once it had been approved by the council, public intervention in the work of private practitioners or voluntary agencies would be legitimate, since it would then be based on the agreement of a majority of the community.

The medical profession in general tended to dislike lay control over their practice. It was proposed in the plan published by the BMA in 1930 that medical providers should have more direct representation than that through local councils on the local scheme for socialization of medicine, so that their medical opinion could be more adequately reflected. Newsholme, however, opposed the BMA's idea of setting up an ad hoc committee for the local medical scheme, in which representatives of the providers would

[51] A. Newsholme, 'Some conditions of social efficiency in relation to local public administration', *Public Health*, 22 (1908–09), p. 413.

[52] Newsholme, *Medicine and the State*, p. 48.

[53] *Ibid.*, p. 50.

have the majority.[54] In his view, any public medical scheme should be subject to government by elected representatives of the general public.[55]

3.2. Central and local government

Since the early 20th century, the leaders of the medical profession had persistently tried to ensure their professional influence on health policy-making at the national level. When the new MH was established in 1919, they succeeded in gaining a place for their representatives in the Consultative Council (chaired by Dawson) of the new Ministry. It is interesting in relation to the Consultative Council that Newsholme described 'the giving of representation on an administrative or investigating body to the "interests concerned"' as 'the commonest' of 'less obvious forms of corruption' in Britain.[56] He was apparently apprehensive that, through such a body, a small group of medical leaders would insist on their interests and exert a decisive power on health policy-making. Citing Newsholme's apprehension, Richard Titmuss pointed out in the 1950s the increasing tendency towards professional dominance of social administration.[57]

Newsholme placed much emphasis on the balance between central and local government and between expertise and democracy. While central control over local health administration was necessary and desirable, especially in connection with 'grants-in-aid', the amount of interference with local self-government should be kept at a minimum.[58] In arguing for the importance of democratic government, he referred to the case of Edwin Chadwick and his expert advisors. Newsholme saw a defect in their 'excessive zeal' for centralized, expert-oriented reform, in other words, their failure to acknowledge the situation of public opinion.[59]

Such centralist, elitist zeal was inherited by the Webbs. It should be noted, however, that they, especially Beatrice, also placed much emphasis on local self-government: there was a tension between centralist and localist elements in their thought.[60] They thought that the existing machinery had to be reformed drastically at once, in order to secure successful local self-government. They aimed to introduce a nationally uniform local government system in which experts should play an important part, by breaking up poor-law administration, which was in the hands of amateur guardians. Because the Webbs fought hard at the centre, assisted by their expert friends, for the new system to be introduced all at once under the strong initiative of central government, the centralist and elitist elements in their thought seemingly came to the front. It can be argued that they tended to assume a centralist approach to the reform process, though they did not necessarily envisage centralization as the outcome of reform. In contrast, Newsholme sought a localist approach not only to reform outcomes but also to reform process,

[54] *Ibid.*, pp. 105–6.

[55] Ibid., p. 48. See also Newsholme, *The Ministry of Health*, pp. 82–3.

[56] Newsholme, *The Ministry of Health*, pp. 83–4.

[57] R. M. Titmuss, *Essays on 'The Welfare State'* (1958), 3rd edn. (1976), p. 27.

[58] Newsholme, *The Ministry of Health*, pp. 93, 111–3.

[59] *Ibid.*, p. 86.

[60] J. Stapleton, 'Localism versus centralism in the Webbs' political thought', *History of Political Thought*, 12 (1991), pp. 147–65.

thinking that such a system should be established piece by piece on the basis of local political consensus.

Similarly with the Webbs, the founders of the MH, Addison, Morant and Newman, were, in principle, advocates of a sound balance between central and local government and between expertise and democracy.[61] However, they tended to assume that the LGB's indecisive manner in guiding local authorities because of the weak presence of medical experts in the Board had resulted in tardy policy innovation and implementation.[62] Thus, in contrast with the LGB, the MH emphasised on medical professional dominance and positive intervention from the centre. It was expected that progress in improvement of the health care system could be made more quickly under the strong, professionally well-advised central ministry.

In practice, however, the MH failed to act very differently from the LGB.[63] Financially, the Treasury's rigid control continued to be a constraint. Politically, it was difficult for the Ministry officials to act drastically, while balancing central and local control, and bringing expert opinions (which were by no means homogeneous) into conformity with democratic procedure. In consequence, rationalization and socialization of medical provision proceeded only slowly and unevenly during the inter-war period. While local authority medical provision came to fore in cities and large towns, there were still many local authorities which did not or were not able to develop their medical provision promptly. Coordination of medical provision between private practitioners, voluntary hospitals and the local authorities remained difficult in general, while successful, if partial, coordination was seen in many localities.[64]

Newsholme was aware that it was difficult and time-consuming to pursue the socialization of medicine by coordinating existing organizations under 'democratic government'. Yet, in his view, 'delayed reform, when slow and hesitant, is preferable to extreme activity'.[65] He seems to have been optimistic about the working of democracy in Britain, and about the possibilities for socialized, well-organized medical provision under it. He was fond of quoting the words of the US Senator, Elihu Root: 'Pessimism is criminal weakness' in democratic government.[66]

In 1932, Newsholme visited the USSR for about four weeks to investigate its medical system with John A. Kingsbury, Secretary of the Milbank Fund in New York. The outcome was *Red Medicine*, published in 1933, under joint authorship with Kingsbury. The Soviet government had nationalized the entire medical practice in the country, to provide universally free medical services. Newsholme and Kingsbury observed that, at

[61] See e.g. G. Newman, *Health and Social Evolution* (1931), pp. 95–125.

[62] Bellamy, *op. cit.*, pp. 253–4.

[63] S. Stacey, 'The Ministry of Health, 1919–29: Ideas and Practice in a Government Department', D. Phil. thesis, (University of Oxford, 1984), Chapter 2.

[64] Abel-Smith, *op. cit.*, pp. 368–83. For a recent assessment of local authority medical provision, see M. Powell, 'An Expanding Service: Municipal Acute Medicine in the 1930s', *Twentieth Century British History*, 8 (1997), pp. 334–57.

[65] Newsholme, *The Ministry of Health*, p. 86

[66] *Ibid.*, p. 83; Newsholme, *Medicine and the State*, p. 51.

the time of their visit, the state medical service was available for the vast majority of the urban population, and its extension to rural areas was under way. It is easy to detect the authors' admiration for the rapid socialization of medicine in the book.[67]

Meanwhile, the authors expressed a good deal of caution about the autocratic aspect of the Soviet system itself.[68] However, in their book, such critical issues were not sufficiently discussed in relation to health administration. They seem to have hesitated to assert that the rapid socialization of medicine, which they admired, was related to the autocratic system. Eyler's examination of the correspondence between Newsholme and Kingsbury has revealed that there were differences in opinion between the two authors in the making of *Red Medicine.* It was Newsholme who entertained the deeper suspicion of the Soviet system. The relatively uncritical Kingsbury tried to convince him that the book should concentrate on the bright side of the Soviet medical system. Kingsbury cited the Webbs' support for the Soviet system to appease Newsholme. Newsholme himself went to see the Webbs for advice. Sidney Webb objected to Newsholme's critical remarks, insisting that the Soviet system was fundamentally no less democratic than the Western democracies. However, while thinking highly of Webb's authority, Newsholme did not share Webb's positive view of the system of government in the USSR.[69]

Newsholme contrasted the USSR, which had rushed 'impetuously and bald-headed' into the socialization of medicine and attained unification of public health and general medical work 'at a stride', with Western countries which were advancing 'only slowly and incompletely'.[70] But, 'can one approve of the present position in Soviet Russia?', questioned Newsholme, in view of 'gross injustice' under the 'dictatorship'.[71] He found it 'impossible to give a single answer, either affirmative or negative, to this question'.[72] He was obviously in a dilemma: while he was appreciative of the rapid socialization of medicine and efficient administration in the USSR from a medical point of view, his respect for democratic government kept him from approving them unconditionally.

[67] A. Newsholme and J. A. Kingsbury, *Red Medicine: Socialized Health in Soviet Russia* (1933), UK edn. (1934), pp. 308–12.

[68] *Ibid.*, p. 296, 302.

[69] Eyler, *Sir Arthur Newsholme*, pp. 368–9. Eyler's account, however, gives the impression that Newsholme had not been aware of the possibility of crude bureaucracy in state medical schemes until his visit to the USSR (see *ibid.*, p. 217). This seems to be because, while noting Newsholme's trust in the British system of local government, Eyler does not pay suffictient attention to Newsholme's emphasis on the role of local politics. As we have observed earlier, Newsholme urged unification of health services under local authorities, in order to make the most of not only the role of local health officials, but also to boost the function of the local authorities as councils of the local people. He expected that the arbitrariness of officialism could be checked in the process of local politics. Newsholme's difference from the Webbs had already been noticeable around the time of the Royal Commission on Poor Laws. While the Webbs insisted that a complete plan for an expert-oriented, local-authority-based administrative system should be implemented immediately, Newsholme thought that such a system should be established gradually on the basis of local political consensus.

[70] A. Newsholme, *The Last Thirty Years in Public Health* (London, 1936), pp. 387, 392.

[71] *Ibid.*, p. 382.

[72] *Ibid.*, p. 387.

It is understandable that Newsholme was more cautious than the Webbs about the Soviet medical system, which was established drastically by means of strong central bureaucratic powers. Newsholme's criticisms of the USSR were consistent with his belief in the need for gradualism in order to build democratic consensus, from the grass-roots upwards, if effective institutions were to be built. In defending the existing machinery of public health administration in England throughout his career, he was well aware of the democratic devices which had been put into it at its establishment in the 1870s.

CONCLUSION

Newsholme can be regarded as one of the early champions of a National Health Service: he had envisaged a comprehensive public medical system open to everyone in need. He thought, like Fabian reformers, the Socialist Medical Association, and senior MH officials, that such a system should be administered by the existing local authorities, which were thought to be agents of preventive medicine and of local democracy. But, in his thinking, anxiety to introduce a nationally uniform local-authority-based system at once by means of strong central government powers was relatively weak. Being cautious about centralization either as a process or an outcome of reform, he advocated piece-by-piece extensions of socialized medical provision in each locality on the basis of local political consensus, while supporting some pressure and help from the centre. It seems that he tried to balance his professional aspiration for a comprehensive public medical system with current notions of local self-government, or of voluntary involvement of local citizens.

It would be reasonable to connect Newsholme's preference for local government with his early experience in Brighton. Brighton had advantages in forming a local consensus around public health measures. Since the town's prosperity was dependent largely on its health image as seaside resort, civic consciousness in relation to public health was fairly high. Thanks to its prosperity, Brighton could afford to invest in a public-health infrastructure relatively easily. Due to his relatively fortunate experience at the local level, Newsholme was able to maintain his sympathy with the English tradition of local consensus seeking administration, and tried to be optimistic about it, even when the progress of reform was not smooth. It can be argued, however, that Newsholme was too optimistic about the working of local government. Not every locality had conditions as favourable as Brighton. With a piece-by-piece approach, it could not be foreseen when the comprehensive system would be completed all over the country.

Newsholme died in May 1943, at the age of eighty-six. Meanwhile, desire for a comprehensive public medical system culminated under wartime conditions. The Coalition Government, acting basically along with the lines MH officials advocated, drew up a provisional plan to unify all the medical services under the control of local authorities. But it was fiercely criticized by private practitioners and voluntary hospital consultants who disliked local government control.

The struggle continued after the war. Aneurin Bevan, the Labour Minister of Health, chose to resolve the political struggle with the medical profession at the national level,

rather than in each locality through the medium of local councils. He abandoned plans for a local-authority-based system, partly because the medical profession's opposition was persistent and partly because Bevan himself was not quite confident in the ability of existing local authorities. The NHS, launched in 1948 under his initiative, was not a unified system under local government control but a nationally directed and financed tripartite system consisting of the hospital, primary care, and community service divisions: the hospitals were nationalized and managed through regional hospital boards (except the teaching hospitals whose management was left to each board of governors); primary care was provided by GPs, who retained a large share of independence; the only responsibility that was left in the hands of the local authorities was the management of community health services such as prevention, home visiting and ambulances.[73]

Thus, unlike the reform process and outcomes that Newsholme had envisaged, the comprehensive public medical system was established at a burst by a resourceful central minister, and within it the role of local government was limited: Bevan abandoned both a localist approach to reform process and a unified service under local government control as the outcome of reform. Bevan's effort was certainly admirable and his treatment of local government perhaps justifiable in view of the necessity to establish a comprehensive system promptly by resolving complicated political and technical problems. It is beyond the scope of this paper to judge which plan should have been adopted.[74] Yet, we should point out that, when we compare the established NHS with Newsholme's plan, the merits of a locally formed and managed public medical system of the kind that Bevan abandoned warrant reconsideration.

[73] C. Webster, *The National Health Service: A Political History* (Oxford, 1998), pp. 2–28; V. Berridge, *Health and Society in Britain since 1939* (Cambridge, 1999), pp. 10–8.

[74] It would be naive to assert that a better system would have been created if Newsholme's idea of local-authority-based policy-making had been adopted: the existing local government system was by no means free from problems.