

Medicine in the Community: Integration, Health Centres and the NHS in Scotland 1948-74

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There are two general issues I would like to raise in this paper relevant to 'medicine health and independent contractor services as can be seen in the organizational chart for the NHS in England and Wales in **Figure 1**.

The dominant and most original feature of Aneurin Bevan's scheme lay in the nationalization and in the community' both past and present. The first is the distinctiveness of health services in Scotland and within different parts of Scotland; the second is the integration, or at least co-ordination of health services. Along the way I hope to show that organization charts and building plans can be riveting!

Currently I am working on a project on the history of the National Health Service in the West of Scotland from 1948 until the first major re-organisation in 1974, and one aspect of this – the history of health centres – opens up these themes of distinctiveness and integration particularly well.

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Charles Webster has pointed out that the British National Health Service is of particular interest because it exemplifies the most unusual of the three general patterns of health care in Western economies. Instead of either a system of public subsidies to private insurance funds or compulsory levies in support of national insurance schemes, the state assumes direct powers to provide medical care for the entire population, taking over ownership of institutions where health care is provided and employing health personnel. His two volume official history of the National Health Service in Britain and his shorter

history published for the 50th anniversary in 1998 give a comprehensive overview of the advent of the NHS in terms of national policy formation and implementation, but inevitably it gives a top-down view.¹ The variations in experiences of the introduction of the NHS in different localities are only beginning to be explored systematically. These tend to focus on the regional hospital boards, the main administrative innovation of the new service and subject of reorganisation in 1974, and pay less attention to general practice and local authority provision. What is needed now is the exploration of regional variation in the implementation of national health policy and delivery of medical services in Britain focusing on all branches of the NHS and how these changes were shaped and experienced in particular locations. The importance of a regional or local perspective is clear from John Pickstone's work, showing how local concerns and initiatives produced a distinctive, innovative pattern of development of psychiatric units in district general hospitals in Manchester around 1950, 'not in response to national policy but because of the way new regional decision-makers reacted to peculiar problems in the provision and staffing of mental health services'.² This paper focuses on the distinctive history of health centres generally in Scotland and on two contrasting initiatives in the 1960s and 70s - one in Livingston, near Edinburgh, the other in Glasgow. This will, I hope, illuminate both regional variations within Britain and between areas of Scotland and the difficulties and possibilities of integration of the tripartite structure of the NHS.

The Tripartite Structure of the NHS

It is necessary first to outline very briefly the tripartite structure of the NHS. When the British National Health Service emerged on the Appointed Day 5 July 1948 medical services became universal (i.e. available to all), comprehensive (i.e. all services both preventive and curative), and free at the point of delivery (i.e. financed primarily directly

*I am grateful to the Wellcome Trust for the funding that has made the research for this paper possible.

¹ C. Webster, *The National Health Services since the War* (London: HMSO, 1988 and 1996); idem, *The National Health Service: a Political History* (Oxford: OUP, 1998).

² J. Pickstone, 'Psychiatry in District General Hospitals' in J. Pickstone (ed) *Medical Innovations in Historical Perspective* (1992), pp. 185-99.

from the national exchequer with a small proportion from national insurance contributions). But, unification of all health services under a single system of administration was regarded as impractical; instead due to the legacy of the past, the adamant refusal of general practitioners to be swallowed up in a unified system and the political compromises involved in the legislation and lead up to its introduction, it had a tripartite administrative structure. There were different forms of administration for hospitals, public regionalization of the hospitals (circled in blue on Fig. 1). It made possible the integration of all types of hospital under Regional Hospital Boards appointed by the minister and responsible for the application of government policy, overall strategic planning, budgetary control and some specific duties such as the development of specialities and appointment of hospital consultant doctors. The municipal hospitals were taken away from the local authorities, but through their Medical Officer of Health the local authorities (circled in black on Fig. 1) remained in charge of functions such as maternity and child welfare, domiciliary midwifery, health visiting, home nursing, home helps, vaccination and immunization and other activities connected with public health and health education. They were also responsible for health centres (circled in red on Fig. 1). Finally, the scheme also allowed for the separate administration of services provided by independent contractors, i.e. general medical practitioners, general dental practitioners, opticians and pharmacists (circled in green on Fig. 1). At the local level, committees, called Executive Councils but essentially renamed committees inherited from the previous panel system under the 1911 National Insurance system, administered their services. The Executive Councils in the main followed the geographic pattern of the local health authorities, but there were longstanding tensions between the two as the general practitioners adamantly resisted any suggestion that they become salaried employees of the local authorities.

Not only did the NHS have a tripartite structure, but the NHS in Scotland was introduced on the Appointed Day under separate legislation and although the administrative structure in Scotland was basically the same, there were some differences (**Fig. 2**). For example, the minister and department responsible for the service was the Secretary of State for Scotland and the relevant department in the Scottish Office rather than the Minister of Health and his department, the teaching hospitals were under the Regional Hospital Boards in Scotland while those in England went directly to the Minister, and, as we shall see below, there was a difference in responsibility for health centres (circled in red on Fig. 2). In England they were the responsibility of local authorities; while in Scotland they were a direct responsibility of the Scottish Office.

Both contemporaries and historians have pointed to fragmentation of the provision of health services as a major problem before the NHS. Coordination, cooperation and integration were major policy aims of policy-makers in the interwar years and leading up to the NHS. Although there was an unprecedented amount of restructuring achieved with the NHS Acts, the tripartite administrative system risked creating a series of parallel, unequal, incompatible, uncoordinated, unintegrated health services. This was counteracted centrally both by promises of active intervention on the part of the minister and by high expectations of a complicated system of central consultative committees, and locally by the provision and maintenance of health centres intended to house both local authority staff and independent contractors. Thus, health centres played a highly important role in the initial plans for the NHS and had a different administrative position in England and Scotland.

Health Centres

The concept of a health centre has a variety of meanings. In the United States George Rosen and most recently William Rothstein have reminded us of the widespread movement between 1910 and 1940 and again in the late 1960s and early 1970s when local

public health departments or private agencies established centres providing health services on a local basis. These neighbourhood centres were aimed at the urban poor. In New York City the neighbourhood health centres grew out of milk stations and the bureaucratic problem of what to do with school nurses in the summer. Hitherto most nurses had specialised in a particular medical problem, such as maternity, infant care or tuberculosis; in the health centres a nurse or provided all the health care for a number of families. Like many local authority health services in Britain, the health centres in the United States generally emphasized prevention. Yet, although most medical care concerned with diagnosis and therapy remained outside their sphere of activity, they treated diseases considered public health problems such as tuberculosis, venereal diseases and fever, which constituted the major health problems of the poor, and as a result they were able to provide the main types of health care required in the neighbourhoods they served. By 1939 the public health department in New York City had established thirty health centres. They focused on families, holding family record cards, and integrated social services as well as health services in buildings serving districts of about 250,000 residents each.³

In Britain in the 1920s a different idea of a health centre emerged. They were designed to foster more integrated and active citizens through new approaches to health care delivery. The Pioneer Health Centre at Peckham in London was established embodying a conception of positive health, personal responsibility and the family unit; it encouraged a healthy lifestyle, individual responsibility and provided a family social centre to promote community integration.⁴

A still different concept of health centre appeared in 1920 in the Dawson report sponsored by the Ministry of Health which described the health centre as the future

³ George Rosen, 'The First Neighborhood Health Center Movement: its rise and fall' in R. Numbers and J Walzer Levitt, *Sickness and Health in America: readings in the history of medicine and public health* 2nd edn (Madison, Wisc.: University of Wisconsin Press, 1985, pp. 185-200. (first published 1971); William G Rothstein, 'Bureaucratic Creativity and Professional Conservatism: Neighborhood Health Centers in New York City, 1900-1980', paper delivered at the annual conference of the American Association for the History of Medicine, Boston, 2 May 2003.

⁴ Abigail Beach, 'Potential for Participation: Health Centres and the Idea of Citizenship c.1920-1940' in C. Lawrence and A-K Mayer (eds) *Regenerating England: Science, Medicine and Culture in Interwar Britain* (Amsterdam: Rodopi, 2000, pp. 203-230.

direction of primary health care provision. They were a means to integrate preventative and curative medicine. The medical practitioners were central to Dawson's view of the health centre which was local but had little sense of mass participation beyond the view that the people themselves should be in large part responsible for their own health with responsibility fostered through on-going health education.⁵

Dawson's concept of health centres was cited as a precursor but in the context of the NHS health centers had different, yet still varied meanings.

Health Centres in Scotland 1946-60: the Scottish Health Department Programme

Accounts of the implementation of the provisions for health centres in the National Health Service Acts emphasize the very small number of health centres opened and the lack of enthusiasm of the government health departments.⁶ This appears to have been the case in England where responsibility for health centres rested with local authorities. But, a close look at Scotland, where the responsibility was the Secretary of State's, reveals that the Scottish Health Department tackled the provision with energy and determination, developing an experimental program and adapting it when expenditure cuts required, but eventually it was thwarted by the Treasury.

In just over a year, beginning in August 1946 when the legislation to establish the NHS was still under consideration and ending in September 1947 many months before the Appointed Day, the Scottish Health Department produced a comprehensive memorandum setting out an experimental programme for the provision and maintenance of health centres, complete with an architect's plans of a typical health centre that could be adapted to varied situations in light of experience. Anticipation of its new responsibilities and pressure from the 'planning people' for guidance for planning health services for new towns spurred the Department into action. In the process it had to create a new planning

⁵ C. Webster, 'The Metamorphosis of Dawson of Penn' in D. Porter and R Porter (eds) *Doctors, Society and Politics: Historical Essays* (Amsterdam: Rodopi, 1993), pp. 212-28.

⁶ J Hogarth, 'General Practice' in G McLachlan (ed) *Improving the Common Wealth: aspects of Scottish Health Services 1900-1984* (Edinburgh: EUP, 1985), p 193. C. Webster, 'The Politics of General Practice' in I Loudon, J Horder and C Webster (eds) *General Practice under the National Health Service 1948-1997* (Oxford: OUP, 1998), p. 22.

mechanism to carry out its responsibilities, as it found there was no alternative to taking on the planning and implementing of the initial programme itself as the alternatives – local authorities, the new hospital boards and the Ministry of Works – were unsuitable.

The plan for the typical health centre (**Fig 3**) was carefully thought through. Although the department took powers to include all three parts of the service, the typical centre combined only GP and local authority services. In Figure 3 the entrance is in the centre, the GP consulting rooms are in the left wing and the local authority rooms are in the right wing. It was not to be a mini-hospital that would make GPs into consultants as one recent commentator has suggested.⁷ Instead, the plan aimed ‘to maintain the personal and intimate character of the best type of present-day general practice. The characteristic relationship between the family doctor and his patients must be preserved and extended as far as possible.’⁸ This set a limit for the size of the building and variety of services. The aim was to include ‘all the services which contributed immediately to the domiciliary health services and of resisting the inclusion of other valuable services such as day nurseries and recreational facilities which should be provided elsewhere’.⁹

The plan considered the content and layout of a health centre in detail, specifying, for example, that there should be a separate waiting room for each doctor and each consulting room should have a separate exit so patients did not go out through a waiting room (**Fig. 4**). In this way it attempted to ‘preserve as far as possible the intimacy of the private consulting room and by providing separate waiting rooms for each part of the service to avoid any congregation of patients in waiting halls’.¹⁰ It set out staffing and accommodation for health centres in a new township with five units of 10,000 each. Each health centre would have 4 GPs, 4 dentists and 1 pharmacist who were independent contractors, as well as child welfare, maternity service and health visitors from the local

⁷ N Bosanquet and C Salisbury, ‘The Practice’ in I Loudon, J Horder and C Webster (eds) *General Practice under the National Health Service 1948-1997* (Oxford: OUP, 1998), p.55.

⁸ National Archives of Scotland (hereafter NAS) HH101/1887, Sept 1947, p. 4.

⁹ Ibid.

¹⁰ NAS HH101/1887, Sept 1947, p. 7.

authority. There would be no provision for day nurseries, out-patient department of hospitals or full-time specialists. Where a clinic centre was being set up in a new town, the hospital accommodation would probably be so situated in relation to the town as to make such provision unnecessary. But hospital provision was not ruled out in areas where hospitals are not conveniently situated.¹¹

The Department proposed an initial experimental programme of four health centres, each in a different type of area. By the Appointed Day in 1948 one site, Sighthill in Edinburgh had been selected, consultations begun, and hopes raised for the start of building in 1949. Building didn't begin until 1951 and it was opened in 1953. Though the trade unions urged the Secretary of State to speed up the programme, financial constraints had begun to set in by the Appointed Day and it was becoming clear that a health centre at the level of cost of Sighthill, £140,000 could not be repeated, so the Department adapted its plans and brought forward a proposal for a centre at Stranraer costing only £20,000 which was accepted and plans for several more at that level were in hand. However, in the early 1950s the Treasury objected to any subsidy of rents for the GPs in the centres and would not agree to a continuing programme. They calculated the economic rent at Sighthill at around £900 per annum while the GPs paid only £300; at Stranraer the economic rent was estimated to be £526 while GPs paid £200.¹² This effectively blocked the department's programme including one it had already approved and others waiting in the wings. Officials searched for ways to fill the gap, including reducing costs further and approaching charitable foundations, but without success. Thus, the Department built no more health centres until the 1960s – not because it lacked the expertise and machinery to plan and implement the centres, nor due to lack of demand, but because of the Treasury's intransigence, the inability of GPs to pay economic rents, and the priority given to building up the hospital services.

¹¹ NAS HH101/1988/16.

¹² NAS HH101/1887, 28 Feb 1957.

Resurgence in the 1960s and 70s

The mid-1960s saw an upsurge of interest in health centres among general practitioners and the Scottish Office and the beginning of a major program. In 1967 two new centres were opened and 48 others were at various stages of consideration. Capital expenditure rose from £10,000 in 1966/67 to £159,000 in just one year and continued to rise. By 1982 there were 157 health centres in operation in Scotland and another 56 were at various stages of construction or planning. Almost 33% of GPs were practising from health centres which varied in size and facilities according to local circumstances, catering for between 1 and 36 practitioners.¹³ In England there was a similar rehabilitation of the idea of health centres, but it began later than in Scotland.¹⁴

Livingston Experiment – initiative from the top

Among the many features that account for this programme and Scotland's lead,¹⁵ was the coming of more pro-active officials in the central departments and the particularly close relationship in Scotland between officials and leaders of the professional organisations. A clear illustration is the innovative Livingston scheme which established health centres in the new town of Livingston near Edinburgh in the mid-1960s and was initiated by the Scottish Home and Health Department. John Brotherston became Chief Medical Officer in Scotland in 1964 and the small number of department officials and leading figures in the profession frequently travelled to London by train or plane and were subject to considerable delays. As one leading GP later remarked in his autobiography, one of the opportunities that came with flying to and from London...[was] the chance ...to have forward looking discussions with....James Hogarth from the Scottish Office and ...John Brotherston. There are at least three projects that I can remember as being born at Heathrow....The second item of airport waiting time gestation was a blue-print for

¹³ J. Hogarth, 'General Practice' in G. McLachlan (ed) *Improving the Common Weal: Aspects of Scottish Health Services 1900-1984* (Edinburgh, EUP, 1987), pp. 200, 206.

¹⁴ Webster, 'Politics', p. 32.

¹⁵ Including for example, the upturn in the economy in the 1960s, a new government in 1964, the feeling that it was the general practitioners' turn for capital investment after the 10 year plan for hospital building was launched in the early 1960s, increasing self confidence among general practitioners with the Doctors' Charter of the mid-1960s.

a Scottish Home and Health Department funded study in the New Town of Livingston, where a GP would also hold a part-time appointment in a major local hospital.¹⁶

The joint appointments of GPs based in health centres as part-time hospital specialists worked well enough at Livingston where a new district hospital was planned at the same time as the health centres, but it was not generally copied.

Glasgow – initiative from GPs

More common was the initiative of general practitioners found in Glasgow. But, while it is generally recognised that much of the initiative for the renewed popularity of health centres came from representatives of general practitioners, in Glasgow, a major industrial city with a population of over a million and notorious overcrowding, the reasons arose from particular local circumstances, namely a uniquely large urban redevelopment programme. And it resulted, not in individual ad hoc initiatives, but in a plan for Glasgow as a whole.

In October 1964 William Fulton, a GP and Secretary of the Local Medical Committee responsible for the administration of general practice in Glasgow, wrote a memorandum entitled ‘An Opportunity to Experiment in Glasgow’ approved by the Local Medical Committee. The memorandum argued that financial incentives for individual practitioners to provide group premises, which had become the policy in place of health centres since the early 1950s, was not appropriate in Glasgow where a huge urban redevelopment programme was going forward and required planning. In the redevelopment areas all (or nearly all) the buildings would be demolished and the whole area rebuilt with a much lower density of population. Doctors in these areas would lose their surgeries, and as yet there were no plans for replacements despite 10 years of consultation between the Corporation and Executive Council and no lack of goodwill; also eventually fewer doctors would be required in Glasgow as a whole. The memorandum

¹⁶ E V Kuenssberg, *Transplant* (memoir printed privately, 1993), pp. 252-3. I am grateful to his son Mr Nick Kuenssberg for allowing me to read his father’s autobiography.

argued that this was the time for the central authority to act to plan and build a number of health centres and take the opportunity to carry out an experiment that could revolutionize general practice in Glasgow. The planning would not be difficult because it could be aligned with the hospital plan in which Glasgow was divided into five sectors and the provision of general medical services could follow this pattern. The premises could take a variety of forms, but the three parts of the NHS are complementary and the needs of the patient would be better served if they were available under one roof.

The memorandum stressed that it should be the responsibility of the central government to undertake the planning and building of the new premises, retaining general practitioners' longstanding opposition to local authority responsibility for centres. It argued that there was no doubt that local opinion would favour the central government agency rather than the local authority so the cost would not fall on the rates. Nor would the relation of the patient to the individual general practitioner change. Each patient had a personal doctor who had continuous responsibility for seeing him or her through all illnesses. It would not be a polyclinic where a group of doctors shared a common responsibility for large blocks of patients. The aim of better organisation was to enable the doctor to waste a minimum of time on non-essentials from the medical point of view and to provide a better and more personal service for his own patients over a wide range of clinical and social aspects of their health.

The LMC released the memorandum to the press and there was wide coverage and approval in the newspapers.¹⁷ The *Scottish Daily Express* suggested that the estimated cost of the centres of £1million was a 'drop in the bucket' compared with the planned expenditure for hospital expansion.

By the end of January the Scottish Home and Health department indicated that it viewed the proposals favourably and invited the Glasgow Executive Council to formally

¹⁷ *Glasgow Herald*, *Scotsman*, *London Times* and *Scottish Daily Express* all carried articles on 23 Oct 1964.

submit their plan, though it stressed that the relevant bodies needed to agree to work together. It called for immediate detailed planning for two health centres in redevelopment areas and for long-term planning to identify the next areas requiring attention. This approval from the centre made it possible for a joint committee in Glasgow representing the GPs, local authority, hospital services and University to be set up which went on to plan the future provision of health centres in the city.

By 1970 there were four centres underway and the Department was asking the LMC to prioritise further areas for health centres in Glasgow. The 'Opportunity for Experiment in Glasgow' had become the 'Glasgow Health Centre Programme'.¹⁸ The first health centre in Glasgow, the Woodside Health Centre, opened in June 1971, and although the programme was fraught with delays particularly due to problems obtaining sites, eighteen were eventually built in the city.¹⁹

Conclusion

The idea of health centres was not new but its meaning varied and they had a special integrating role in the scheme for the NHS in Britain. The general failure to establish health centres in the early years of the NHS left little to counteract the administrative separation of the three branches. The alternative to health centres pursued in the 1950s were limited financial incentives, such as interest free loans, to individual practitioners to build the new premises needed to encourage group practice, but even if fully funded the GPs in Glasgow realized these had limitations particularly in redevelopment areas. The resurrection of health centres in the mid-1960s relied on the initiative of GPs and on cooperation at the local level. As we saw in the plan of the 'typical' health centre at the outset of the NHS, the GPs were not trying to build their own

¹⁸ Greater Glasgow Health Board Archives (hereafter GGHB) HH100/6/1/3, P. Mackay to T H Souter 10 April 1970; T H Souter to P Mackay 13 April 1970.

¹⁹ NAS HH101/3582, 3853. Reveals the frustration of the Glasgow Executive Council at the delays in the programme and the problems finding sites in the redevelopment areas.

mini-hospitals, but were trying to recreate the advantages of the family doctor in more collaborative surroundings.

The revival of health centres from the mid-1960s highlights the importance of looking at the history of the NHS from the bottom up. Even though in the early stages of the NHS in Scotland the Scottish Health Department showed itself capable of planning and building health centres, initiative from the top-down in the Scottish Office in the mid-1960s was limited to Livingston. Yet, Scottish Office support was still essential for the revival of the health centres and implementing local initiatives, and the initiatives and central government backing for health centres in the mid-1960s came first in Scotland in part because of the close collaboration between the medical profession and the Scottish Home and Health Department. As William Fulton, the Glasgow GP and medical politician, commented

we were so often first to be organised in Scotland. It is a small country and we know and trusted each other well enough to get agreement. We did not need long-drawn out negotiations as was so often the case in the South. It was common for senior officers in the Health Department to hold office in [medical organisations]...We hardly needed formal liaison Committees in these days.²⁰

Yet, despite its separate statutory basis and organisation and differences in working relations between officials in the Scottish Office and the medical profession, the Treasury was still able to thwart or encourage initiatives such as health centres. The National Health Service in Scotland was distinctive, yet it was still British.

²⁰ GGHB HB/100/2/2/10 William W Fulton to Denis Pereira Gray, 20 Jan 1992.