

Socialist Proposals for Health Reform in Inter-War Britain: the Case of Somerville Hastings

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The Socialist Medical Association (SMA), founded in 1930 and affiliated to the Labour Party in 1931, has frequently been credited with a crucial role in the creation of Britain's National Health Service. An early published account of the organization by one of its founders, the London GP Charles Brook, quotes a 1946 speech by Harold Laski containing the following passage:

In the short period of fifteen years the Socialist Medical Association has done much to change the perspective and methods of one of the most conservative professions in the world. It has captured the Labour Party; indeed it may be said to have made the Labour Party its instrument in its great adventure.

This speech prompted Brook to write a history of the SMA, which concluded that the 1946 National Health Service Act was "in no small measure" due to the Association. Another founder member, David Stark Murray, made similar claims in a work published in 1971.¹ Some historians have drawn attention to the organization's role.²

The SMA never had a mass following, but within the Labour movement it had on occasions an influence disproportionate to its size, not least because of its strong participation in Labour's "flagship" local authority, the London County Council. And given that its members were drawn from an articulate and well-organized profession, it is not surprising that a number, for example Edith Summerskill, went on to national political prominence. One individual, however, has achieved less attention than he deserves. Somerville Hastings, SMA founding member and first President, was accorded considerable significance by his contemporaries in the world of socialist medical politics.

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¹ Charles Brook, *Making medical history*, London, Percy P Buxton, 1946, pp. 1, 13; David Stark Murray, *Why a national health service?*, London, Pemberton Books, 1971, p. 1.

² Charles Webster, 'Labour and the origins of the National Health Service', in Nicolaas Rupke (ed.), *Science, politics and the public good*, London, Macmillan, 1988, pp. 184-202; Frank Honigsbaum, *The division in British medicine*, London, Kogan Page, 1979; Stephen Brooke, *Labour's war*, Oxford, Clarendon Press, 1992; Arthur Marwick, 'The Labour Party and the welfare state in Britain, 1900-1948', *Am. hist. Rev.*, Dec. 1967: 380-403; Charles Webster, 'Conflict and consensus: explaining the British Health Service', *Twentieth Century Br. Hist.*, 1990, 1 (2): 115-51, pp. 138-9.

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Murray argued that Labour owed Hastings more “than it has ever acknowledged for the working out of a practical health service”, and that no one who knew the SMA’s history could doubt the “most continuous and inspiring role” Hastings played. In an emotional passage, Murray, himself an active medical politician and author, suggested that to the SMA Hastings was “more than a President”. The dinner held in his honour in the early 1950s was an attempt to express what he meant to the organization, “but above all what he had meant to the development of the national health service”. Murray found it impossible to pay “sufficient honour” to Hastings, who had truly led a “remarkable life”. In similar vein, Brook claimed that without Hastings—quietly efficient, persevering, shrewd and kindly—the SMA “would never have made such rapid progress”. Summerskill felt that the “idea of a National Health Service germinated in the hospitable atmosphere” of Hastings’ home and that while “a shy man without personal ambition, . . . [he] was greatly revered by his colleagues in the Labour Party”.³

Clearly, Hastings had a profound impact on his colleagues over a long period, and his ideas were influential in shaping the SMA’s agenda. If the Socialist Medical Association was a seminal organization, then Hastings was a significant individual. This article examines his politico-medical philosophy in a crucial phase, the inter-war period, when he began to clarify his ideas on state medicine. It was then that he was instrumental in forming the SMA, that he participated in the intense debates over national health and, especially, nutritional standards, and first made a political impact, both nationally as an MP, and locally as an LCC councillor. Virtually all the ideas which Hastings was to articulate throughout his long life began to take shape at this time. Hastings’ preoccupations in turn illuminate a number of the key issues of medical concern, both inside and outside the Labour movement.

Hastings’ Life

Somerville Hastings (1878–1967) trained at University College, London, and Middlesex Hospital, London. A Fellow of the Royal College of Surgeons from 1904, he became President of the Laryngology Section of the Royal Society of Medicine in 1928–9. During the First World War Hastings was a captain in the RAMC, and during the Second a member of the Emergency Medical Service. Both before and after his retirement from medical practice in 1945, Hastings was a witness to, and a member of, numerous medical committees and commissions. Politically, Hastings saw himself as a Christian Socialist and was active even before 1914 in the Fabian Society and the Independent Labour Party. In the Edwardian era he also joined the non-aligned State Medical Service Association, founded in 1912, and was a key member by 1915. The SMSA had, however, declined in influence by the late 1920s, when Hastings helped form the more overtly political SMA, remaining President from its inception until 1951. His political commitment between the wars also included two periods, in 1924 and again in 1929–31, as MP for Reading. Election to the LCC as member for Mile End followed in 1932, and after 1934 Hastings was to play a key role in the capital’s health service provision in his capacity as chairman of the

³ Murray, *op. cit.*, note 1 above, pp. 8, 102–4; *idem*, ‘Before our time: the real pioneers of the N.H.S.’, *Medicine Today and Tomorrow*, 1959,

12(5): 6; Charles Brook, *op. cit.*, note 1 above, p. 4; Lady Summerskill, contributing to Hastings’ obituary, *Br. med. J.*, 1967, *iii*: 182.

council's Hospital and Medical Services Committee. Hastings was active in East End politics, serving as a councillor until 1946, and also as chairman of the Poplar League, which ran a successful housing campaign in the late 1930s. From 1945 to 1959 he was Labour MP for Barking.⁴

Aside from his medical and political responsibilities, Hastings was a prolific writer on medical matters, contributing numerous articles to journals and newspapers such as the *Lancet*, the *Labour Woman*, *Medicine Today and Tomorrow*, the *British Medical Journal*, and the *London News*. He also made a number of important foreign trips. In 1931 he attended the inaugural meeting of the International Socialist Medical Association at Carlsbad. The same year he visited the Soviet Union, with his friend and fellow SMA member Alfred Salter MP. This was an experience which had a significant impact on Hastings, as did his 1933 trip to Sweden. The latter's Social Democratic government had, he claimed, begun solving the problem of the transition from capitalism to socialism in matters of health. Consequently, the state-run Swedish hospitals were "the best in the world". The lessons for medical reorganization were clear.⁵

Hastings and Medical Organization

As Hastings' membership of the SMSA suggests, he had a long-standing interest in medical organization. Early evidence of this comes in a co-authored pamphlet of 1910, a response to the Minority Poor Law Report. In any jointly-written piece it is impossible to know exactly what to attribute to whom, and caution needs to be exercised in assuming that Hastings agreed with every sentiment. None the less, issues were raised which were to preoccupy him in the inter-war era. For example, it was claimed that "neglected infancy" led to a "large proportion" of sickness in later life; that an adequate school medical service would save children from "stunting and stultification" due to neglected early minor illnesses; that ill-health was often a factor in "moral or economic decline"; and that the existence of large numbers of very poor, very unhealthy people wasted "valuable brain and muscle" and threatened the community. One conclusion to be drawn from this, and a point made by Hastings throughout his career, was that "health is more important than education". If these were very much the sort of issues Hastings was to take up and expand on in a fairly straightforward way, other passages pointed to potentially difficult areas. Medical autonomy was one. While it was acknowledged that the state would have more to do in medical provision, both organizationally and in the direct employment of certain categories of doctors, the idea that this would reduce doctors' independence was explicitly rejected. The authors were at pains to stress that state employment would set the doctor

⁴ Honigsbaum, op. cit., note 2 above, pp. 327–8; Murray, op. cit., note 1 above, p. 12; Sir James P Ross and W R LeFanu, *Lives of the fellows of the Royal College of Surgeons of England, 1965–1973*, London, Pitman Medical, 1981, pp. 151–2; *Lancet*, 1967, ii: 161, 374; *Br. med. J.*, 1967, iii: 182; *The Times*, 8 July 1967, p. 12; Somerville Hastings MSS, Bundle 2, Biographical Information and SMA archive, DSM 6/1, 'Notes on the History of the SMA', Brynmor Jones Library; Noreen Branson and

Margot Heinemann, *Britain in the nineteen-thirties*, London, Panther Books, 1973, pp. 216–17.

⁵ Charles Brook, op. cit., note 1 above, p. 6; Fenner Brockway, *Bermondsey story: the life of Alfred Salter*, London, George Allen and Unwin, 1949, p. 155; Somerville Hastings, *Medicine in Soviet Russia*, n.p., 1931—reprinted from *Medical World*, 15 January 1931; *idem*, 'The people's health in Sweden', *Socialist Doctor*, 1933, 2(2): 2–3, p. 2.

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free “to think and act in a way often impossible in a private practice”, rather than “crushing individuality”.⁶ This was an issue to which Hastings would frequently return as his plans for a state medical service crystallized.

It is clear from Hastings’ arguments in the 1920s and 1930s that he saw the state as having the key role to play in any reformed system of medical provision. In 1931, he noted the trend away from the family doctor to some form of state medicine, a process bound to continue—partly because of increased efficiency, partly because the “spirit of the age demanded collective action”. Private enterprise had failed “lamentably” in health matters, and it was time for the state to intervene. Addressing the Labour Party conference in 1932, Hastings claimed that the country’s health needs could be provided effectively only by a comprehensive state service. This involved “everything necessary for the prevention and treatment of disease”, and would be “free and open to all”. By 1939 Hastings perceived a state medical service to be “inevitable”, not least because of the continuing expansion of state activity, which in turn implied an acceptance of public responsibility for the prevention of ill-health. Elaborating on this theme, Hastings saw such a service as the only way out of the “present chaos”, that is the complex network of medical provision then in existence. A prerequisite here was for many people to pay for health care, but it was clear that a significant number could not easily manage this.⁷

Problems arose, Hastings argued, from the panel system deriving from the 1911 National Insurance Act. Insured individuals chose a doctor from a “panel”. Panel doctors were paid on a capitation basis from, effectively, public funds. The panel system is often given as an example of increasing state intervention in medicine, in turn leading inevitably to the NHS, but, although supplementing private practice with publicly funded patients, it still perpetuated a system wherein the majority of doctors ran single-handed practices which they were able to sell. As Digby and Bosanquet suggest, this effectively institutionalized the conflict between patients’ interests in improved medical care and those of general practitioners, concerned with improving their living standards.⁸ In Hastings’ view, the huge changes which had taken place in clinical medicine could not be implemented, because no individual, “however capable, can practise it in all its branches”. Treatment had to be linked to prevention, which the panel system was by definition unable to do. Hastings therefore emphasized the need for abolition rather than reform. The panel was an obstacle to, not a step towards, a state medical service. This marked Hastings out from other contemporary reformers.

The system’s problems were linked to the selling of practices. This Hastings found particularly offensive, describing it as a purely commercial and selfish transaction “absolutely ludicrous in a democratic country”. Any extension of the panel system would only make matters worse, so another approach had to be found to ensure “the development of a popularly controlled and efficient socialized medical service”. Hastings was particularly concerned that the Labour Party should not be seduced by the proposals of the

⁶ H Becket-Overy, Somerville Hastings and Arnold Freeman, *The medical proposals of the Minority report*, London, H and W Brown, 1910, pp. 4–9.

⁷ *Report of the thirty-second annual conference of the Labour Party*, London, Labour Party, 1932, p. 269; *Br. med. J.*, 1931, i: 470; Somerville Hastings,

‘Can we afford to leave the nation’s health to private enterprise?’, *Labour Magazine*, April 1931, 543–7, p. 545; *Br. med. J.*, 1939, i: 451.

⁸ Anne Digby and Nick Bosanquet, ‘Doctors and patients in an era of national health insurance and private practice, 1913–1938’, *Econ. Hist. Rev.*, 1988, 2nd series, 41(1): 74–94, p. 93.

British Medical Association and the Medical Practitioners' Union for extending the panel, which he saw as archetypically Tory, subsidizing existing interests "without exacting any measure of popular control".⁹ Written in 1938, this marked the height of Hastings' inter-war scepticism about the panel, something evident as early as 1922. Then he had argued that Labour's health policy would provide a general practitioner service "under much better conditions than under the present panel system". The implication here is that, ultimately, the system would be superseded.¹⁰

However, Hastings was not entirely consistent on this central issue. In *The people's health*, published in 1932 and of considerable influence on SMA policy, he not only acknowledged the existence of the panel but suggested its expansion.¹¹ In part this can be explained by Hastings' recognition that, at least in the circumstances of the inter-war period, no medical system could be built from first principles. The reality and complexity of what already existed had to be taken into account. Hastings also reflected the lack of clarity exhibited by virtually all reformers, socialist and non-socialist, about the detailed workings of any future health system. Furthermore, he was conscious of the antipathy of general practitioners to any diminution of their independent contractor status; their consequent hostility to any form of salaried state service; and their desire to expand, if possible, the scope and amount of panel remuneration. As Webster points out, GPs had developed a strong sense of grievance over earnings by the 1930s, and would have hardly welcomed any proposal to do away with panel income.¹²

None the less, by 1939 Hastings' views were hardening and moving towards the advocacy of a fully comprehensive service in which the panel had no part. In a debate that year he acknowledged that private practice would be permitted under a state service, but "as more and more doctors joined the service it would be progressively superseded". A new system would have to be introduced gradually, but "there was no reasonable stopping-place" between the state's initial involvement in preventive medicine and a complete state service. Hastings had already made this point a number of times, suggesting in 1933 that while private practice would be allowed under a socialized medical system, "the aim would be to make the service so attractive that rich and poor alike would flock to the State doctor at his central clinic".¹³ Noticeable here is the short term tolerance of private practice combined with a long term optimism about doctors voluntarily joining a state service. Hastings was confronting the fears of his professional colleagues over their loss of independence, a matter which, as noted, he had addressed prior to 1914.

Hastings' move towards a fully comprehensive national service led him to examine all aspects of medical organization. He stressed, for example, the importance of keeping proper records. A continuous medical record, he told the Commons in 1931, would be valuable to the nation's health and aid medical research by providing data on the origins of diseases. Hastings further urged the noting down of all significant medical events from "conception to the grave". This concern for record-keeping was not just the working of a

⁹ Somerville Hastings, 'The first steps towards a socialized medical service', *Medicine Today and Tomorrow*, July 1938, no. 10, pp. 3–6, on pp. 5, 3, 4.

¹⁰ *Idem*, 'Labour and the middle class', *Lond. Labour Chron.*, Sept. 1922, p. 7.

¹¹ *Idem*, *The people's health*, London, Labour Party, 1932, p. 16.

¹² Charles Webster, 'Doctors, public service and profit: general practitioners and the National Health Service', *Trans. R. Hist. Soc.*, 1990, 5th series, 40: 197–216, pp. 199, 200.

¹³ *Lancet*, 1939, i: 776; and 1933, ii: 1459.

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bureaucratic mind. It was a critique of the wasteful and overlapping system which currently existed, and which was proving such an obstacle to improved national health.¹⁴

Of central importance to Hastings—partly leading out of his criticisms of the panel system, the sale of practices, and the overlapping and inefficient nature of medical organization—was the health centre. This has been dealt with in some detail by Honigsbaum, and only the more important points made by Hastings need be noted here.¹⁵ He was, clearly, interested in “team-work”. Addressing Middlesex Hospital students in 1923, Hastings cited Darwin as theoretical justification for both competition *and* co-operation in nature. Team-work was especially important in medicine, something “recognised from the earliest times”. Reflecting on his visit to the Soviet Union, he was impressed by the organization of its health centres, or “prophylactoria”. Especially commendable were their apparent efficiency; the medical division of labour which allowed for immediate and direct referral to specialists; the presence of paediatricians and public health officers dealing with sanitary matters; the systematic keeping of records; and the provision of dispensaries. Soviet centres also had educative functions. Public lectures were given on health matters, birth control advice was available, and—presumably in the spirit of health being concerned with the whole person—each centre was regularly attended by a lawyer “to give advice especially to women concerning their rights and those of their children”. Preventive as well as curative medicine was, therefore, practised. This too was a significant feature of Hastings’ policy. *The people’s health* noted that a future medical service would be much more concerned with disease prevention than the present medical service. In the same work, Hastings gave a detailed outline of how health centres would operate. The integration of services and the centrality of the “team” as the fundamental “unit” of health care were stressed, not least because the “complexity of medical science” meant that no one doctor could know everything about all medical matters. Given this text’s influence on the founding document of the SMA, Hastings’ stress on health centres therefore has considerable significance.¹⁶ And while the GP would remain the “keystone” of the system, this was in the broader context of the “team” and “coordination at the periphery”. The ultimate expression of this came in 1938, when Hastings urged the centralization by local authorities in health centres of “their various clinical activities . . . maternity and child welfare, school clinics, tuberculosis dispensaries, orthopaedic clinics, poor-law medical services” as well as ante-natal services, specialist out-patient departments, and, of course, general practice. To aid the integration of health services further, centres should if possible be located in or near municipal hospitals. He strongly emphasized these themes in his Presidential address to the SMA’s first annual general meeting.¹⁷

The hospitals themselves, Hastings argued, should be integrated in one system, in part to facilitate the transfer of difficult cases from one to another. Existing voluntary hospitals

¹⁴ *Parliamentary debates 5th series*, 1931, vol. 255, col. 860; Hastings, op. cit., note 11 above, pp. 6, 12,

¹⁵ Honigsbaum, op. cit., note 2 above, ch. 25.

¹⁶ *Lancet*, 1923, ii: 774–6; Hastings, ‘Medicine in Soviet Russia’, op. cit., note 5 above, pp. 7–9;

idem, op. cit., note 11 above, pp. 9–10, 5; Socialist Medical Association, *A socialised medical service*, London, Socialist Medical Association, 1933.

¹⁷ Hastings, op. cit., note 7 above, p. 545, and op. cit., note 9 above, p. 5; *Br. med. J.*, 1931, i: 865.

should be brought under legislative control, and no new ones founded unless the Ministry of Health could be convinced of the need.¹⁸ The scale of such a proposed reform was huge. By 1938 the voluntary sector in England and Wales had increased its share of patients treated from 25 per cent in 1921 to 36 per cent. Even in London, a stronghold of municipalization, voluntary hospitals in the mid-1930s were providing around 23 per cent of all hospital beds. Despite their profound underlying problems, such hospitals seemed entrenched in the existing system. Hastings, however, was unimpressed, characterizing them as “nursing homes for the middle classes”. He argued for state control while criticizing the standards of care and the methods of extracting payment which voluntary hospitals employed. Rather more sympathetically, Hastings acknowledged the voluntary hospitals’ previous achievements, but condemned their lack of contact with general practitioners and the absence of co-ordination. Consequently, “public health suffered”, and all this made the imminent development of a “National Hospital Service . . . inevitable”. These views were reflected in the SMA evidence to the Sankey Commission in 1936, for which Hastings was largely responsible. This stressed that ultimately “voluntary hospitals should be absorbed into a complete, unified, and coordinated medical service”. Although this was not on the immediate agenda, nine interim proposals were put to the Commission.¹⁹

By contrast, Hastings saw the development of municipal hospitals as “the most striking feature in the evolution of State Medicine during the last quarter of a century”. Consequently they would be central to the development of a state medical system. Like many others on the Left, Hastings saw in the 1929 Local Government Act new possibilities for welfare provision. It was the key to a “complete and unified municipal hospital system”. As Poor Law stigma declined, so would public confidence in municipal hospitals grow. This would lead to an end to the “wasteful system of dual hospital administration”. And Hastings was, as chairman of the LCC’s hospital committee, able to do something concrete about public hospital provision.

By 1939 he was suggesting that the quality of hospital care in the capital had significantly improved because of increased expenditure. “London has reason”, Hastings claimed, “to be proud of its Municipal Hospital System”. This showed the benefits of integration. Specialist care, for example, could be expanded by separating out certain types of patient, who could then be “segregated under the care of doctors and nurses with exceptional experience”.²⁰ Labour spokesmen besides Hastings were certainly proud of the achievements of the LCC hospital services. In 1946 Brian Barker, in a partisan tribute to the Labour LCC, pointed out that during Hastings’ regime maternal death rate per thousand births had fallen dramatically, from 7.2 in 1932 to 2.49 in 1937, while ante-natal clinic attendances had risen from 48,618 to 132,270.²¹ The decline in maternal mortality, although mirroring a national trend, was none the less impressive, London under Labour going from well above to below the national average.

¹⁸ Hastings, *op. cit.*, note 11 above, pp. 11, 18–19.

¹⁹ Brian Abel-Smith, *The hospitals, 1800–1948*, London, Heinemann, 1964, pp. 385, 320–1, 365; Brian Barker, *Labour in London*, George Routledge and Sons, 1946, pp. 136–7; *Lancet*, 1926, i: 180, and 1936, ii: 353.

²⁰ Hastings, *op. cit.*, note 9 above, p. 4; *Lancet*, 1934, i: 1136; *London News*, June 1939, p. 3, and April 1939, p. 8.

²¹ Barker, *op. cit.*, note 19 above, p. 149.

Doctors, Professional Status and Democracy

Two other aspects of Hastings' attitude to medical organization should be mentioned. Hastings had, on one level, little time for his fellow-doctors. Predominantly middle-class in origin and conservative in outlook, they would "stick together like leeches and defend one another if attacked" in a way unique to their profession. They could certainly not be trusted to regulate their own affairs. Discussing medical education, Hastings condemned the profession's recruitment "from a small proportion—approximately one sixth—of the population". This ignored the talents of the majority. State scholarships were needed, and Hastings looked approvingly at the Swedish and Soviet methods of recruitment. A broader spectrum of British candidates would elicit the kind of student with "some knowledge of the world as it really is. His outlook will not be confined to the nursery and public school as was the case with so many of us." Because of his background, such a candidate would more fully appreciate "the importance of environment in the aetiology and prevention of disease". Even under the present system much medical education funding came from the state. The doctor should not, therefore, regard himself as "merely . . . a private trader". In a democratic, socialist health system, doctors had to be much more representative of, and responsive to, the circumstances of their patients, and a wider society, than was currently the case. Patients also had specific rights, these deriving from their status as citizens in a democracy and as consumers in a health service run for democracy's benefit. The doctor must be "at the service of his patients", and the latter should be free to choose their own doctor.²²

But medical democracy went only so far. If Hastings was sceptical of the social and political behaviour of his fellow-doctors, and conscious of their inability to know everything in an increasingly complex world, they were professionals with more knowledge and expertise than any lay person. The public were perceived as being "extraordinarily bad judges of a doctor's worth"; an attitude which sat rather uneasily with his plans for democratic control of a future state medical service. In medical matters at least, the doctor knew best and, Hastings suggested, it was "very difficult for the public to appreciate what is essential for the adequate treatment of disease". This was elaborated on by Hastings and Brook. The two warned against the National Government's proposed economy cuts and their possible impact on health. Only the medical profession could be "fully cognizant of the importance of the issues involved" and doctors therefore had the duty "to protect their fellow countrymen". Given the complexities of modern medicine, even greater training would be needed in the future, thereby reinforcing professional status. Although the GP was to remain the cornerstone of the system, more state examinations were needed to get rid of the dangerous fallacy "that *any* doctor is capable of undertaking *any* form of medical treatment"²³ (my italics).

The emphasis on professional status in Hastings' writing is evident in an otherwise incomprehensible remark, given his view of his colleagues as middle-class and self-seeking. Addressing the Paddington Medical Society, he suggested that a socialized medical service "should appeal to the most socialistic of all the professions, for . . . doctors more than any others practised socialism. Their discoveries were, by tradition, broadcast to the world, and

²² Quoted in Honigsbaum, *op. cit.*, note 2 above, p. 206; *Lancet*, 1932, i: 1213; Hastings, *op. cit.*, note 11 above, p. 6., and *op. cit.*, note 9 above, p. 6.

²³ *Lancet*, 1933, ii: 1459; Hastings, *op. cit.*, note 9 above, p. 4; *Br. med. J.*, 1932, ii: 990-1; *Lancet*, 1932, i: 1214.

their charges were made according to the means of the patients".²⁴ There was a tension in Hastings' work between his acknowledgement of the legitimate role of the citizen in a democracy and the primacy of professional knowledge, something increasingly beyond the comprehension of the average lay person in an age of rapid medical advance, but which at its best could provide a practical example of disinterested, altruistic human endeavour.

Two very obvious ways in which this centrality of professional knowledge manifested itself were in Hastings' attitude to family allowances and to maternal welfare. The Labour movement in the 1920s and early 1930s was torn between advocates and opponents of cash allowances payable directly to mothers. Hastings argued against any such scheme. He told the joint Labour Party/TUC committee that in health matters "mothers cannot be expected to have expert knowledge. With the best intentions they may often provide quite unsuitable food etc.". Money would best be spent on social services. Such evidence was clearly influential in the rejection of cash family allowances by the TUC and, consequently, the Labour Party.²⁵ Hastings defended his position on cash allowances in the wake of the TUC decision. While at pains to praise the working-class mother, he repeated his doubts about her ability to spend money in the best possible way. Too often expenditure might be made on foods with little nutritional value. If public money was to be spent on children, as "vast sums" should be, it would be better spent on a comprehensive medical service, providing children with all their health needs at no cost to parents. This was best for the child and economically efficient. The similarity of views on the abilities of working-class mothers expressed by the socialist Hastings and non-socialist reformers in the child and maternal welfare fields is striking here, suggesting perhaps that patriarchy was as important as professionalism.²⁶ So comprehensive collective services, planned and run by professionals, represented the organizational approach best suited to improving the nation's health.

This attitude also emerges in Hastings' ideas about maternity. Maternal mortality remained high in the 1930s, and was a matter of widespread political concern. Hastings suggested that systematic ante-natal care could identify and thereby deal with "at least half the conditions" contributing to death in childbirth. Mothers should be encouraged to give birth in a maternity hospital which, together with support services, should fulfil rigorous criteria of efficiency. Once again, Hastings appears to have been in part influenced by conditions in the Soviet Union, where it was claimed that 98 per cent of births took place in hospital and the maternal mortality rate was 2.5 per 1,000. His views were carried into the SMA's founding statement, and strongly influenced its subsequent maternity policy. More generally, they were part of the contemporary debate over the causes of maternal mortality, including the shortcomings of GPs in domiciliary delivery.²⁷ For Hastings,

²⁴ *Lancet*, 1932, i: 838.

²⁵ Trades Union Congress and the Labour Party, *Joint Committee on the Living Wage etc.: interim report on family allowances and child welfare*, London, TUC and the Labour Party, 1928, p. 23; Trades Union Congress, *Family allowances*, London, TUC General Council, 1930.

²⁶ *Labour Woman*, 1 Aug. 1930, pp. 121–2. Not surprisingly, Hastings took some criticism for this—see *Labour Woman*, 1 Sept. 1930, pp. 137–8, and Hastings' rather feeble reply, Oct. 1930, p. 153. For

attitudes to working-class mothers, see Jane Lewis, *The politics of motherhood*, London, Croom Helm, 1980, *passim*.

²⁷ Hastings, *op. cit.*, note 11 above, p. 13, and, *Medicine in Soviet Russia*, *op. cit.*, note 5 above, p. 6; Socialist Medical Association, *op. cit.*, note 16 above, p. 12; SMA archive DSM 4/1, typescript on 'The maternity and child welfare services', Brynmor Jones Library; Irvine Loudon, 'Deaths in childbed from the eighteenth century to 1935', *Med. Hist.*, 1986, 30: 1–41, p. 37.

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maternity services were to be integrated into a broader health system, but based in a local health centre. In turn, this was a rejection of the multiplicity and overlap of existing systems, whereby, for example, an expectant mother was faced with a wide range of services from which to choose.²⁸

Hastings did, however, realize that a policy of coercing every woman into giving birth in hospital might prove impossible, however desirable he thought it. While still emphasizing the need for professional care, he suggested that for “apparently normal pregnant women” insisting on home delivery, midwifery services should be provided, backed up where necessary by an obstetrician. Again, his central role in LCC health provision enabled Hastings to do something about this. In 1937 he reported that the LCC, both in its own right and in association with various voluntary organizations, had taken advantage of the new Midwives Act. A comprehensive system, approved of by the Ministry of Health, had been created whereby some 200 midwives were now at the call of London mothers. Constant advice and monitoring were built into the system, which was to be run primarily by the LCC in conjunction with borough councils. Although fees could be charged, a remission system operated for those unable to pay. With the onset of labour, the LCC midwife would arrive “armed with sterilised equipment”. In the event of mishap, or advice being needed, the midwife could call in a specialist at no extra cost. Following the introduction of the London service, Hastings was arguing by 1937 that under favourable conditions home confinements were just as safe, and possibly even safer, than those in hospitals. All this assumed, of course, that proper professional medical standards were observed.²⁹ What united these two apparently contradictory approaches was the way in which Hastings sidestepped general practitioners, replacing them with specialists, thereby again emphasizing the complexity of modern medical knowledge. For Hastings, the London experience showed how a body like the LCC could deliver high standards of integrated, and where necessary, specialist, health care.

Hastings and Local Government Control

The organization of London’s midwifery service leads into the second organizational point, that of local government control. Hastings was clearly proud of his involvement in the LCC, which took up a large part of his active political life. As his obituary in *The Times* noted, he “regarded his 10-year period as chairman of the Hospital and Medical Services Committee of the London County Council as one of the most rewarding of his career”.³⁰ The LCC was a sympathetic environment for Hastings, providing him with a platform within the wider Labour movement and also the stimulus of like-minded colleagues such as fellow SMA members Brook and Salter, and the educationalists Barbara Drake and R H Tawney.

From its inception the SMA played a role in London politics, and was responsible for the 1931 election leaflet ‘For a healthy London’. From 1934 it had seven members, and one associate member, on the LCC. It is therefore significant that the LCC has been

²⁸ Charles Webster, *The health services since the war*, London, HMSO, 1988, vol. 1, p. 7, citing Titmuss on the situation in London.

²⁹ Somerville Hastings, ‘Municipal midwives for

London mothers’, *Labour Woman*, Nov. 1937, p. 169; *London News*, Aug. 1937, p. 5.

³⁰ *The Times*, 8 July 1967, p. 12.

described as being, in the 1930s, “very much a pacesetter in the field of the municipal health services”; and Hastings, as chairman of its hospitals committee, credited with building “the finest municipal hospital service in the land”. Given the size of LCC hospital provision, which was probably as big as the entire English and Welsh voluntary sector, and possibly the largest hospital authority in the world, this strongly reinforces the notion of Hastings’ significance in medical politics.³¹ He was also involved in other London health issues. On school meals and medical inspection, for example, he urged the LCC Education Committee in 1933 to consider the adequacy of current inspection arrangements. Hastings also participated in the London Labour Party’s Health Research Group, which in 1934 produced a blueprint for medical reform in the capital. Such activity bore fruit in the wake of Labour’s 1934 electoral victory. More widely, by the late 1930s, LCC policy influenced considerably the debates over future national policy, with Hastings again having a central role.³²

Local government was more than simply a convenient platform; it was, for Hastings, the key to medical organization. His experience on the LCC contributed strongly to this approach, which in turn determined SMA policy. Honigsbaum finds this emphasis “immutable” right through until the foundations of the NHS itself.³³ This set of values was enshrined in Hastings’ attitude to municipal hospitals, which he saw as increasingly recognized by the public as theirs by “right of citizenship”. This was important since in the event of something going wrong, individuals would have the “right of protest through their elected representatives”. But even within a general context of democratic control, Hastings made it clear that, on medical matters, the “sole determining voice” should be given to medical staff, and that professional opinion must have the right of direct access to the controlling local body. In the last resort, however, he conceded that the elected body should have control over medical appointments, albeit with professional advice.³⁴

As we have seen earlier, the health centre was at the core of Hastings’ thought as an institution that could be integrated into local structures. Hastings had responded positively to the Poor Law Minority Report which had “held up the local authority health services as the model for the future”. He had also contributed to the 1921 Labour Party report recommending the institution of health centres under democratic local control.³⁵ Hastings saw a state medical service as, in essence, built from the bottom up. Although the precise details varied over time, his general plan, as he explained in 1938, was to transfer,

³¹ Murray, op. cit., note 1 above, pp. 24–5; Charles Brook, op. cit., note 1 above, p. 6; SMA archive DSM 6/1, ‘Notes on the history of the SMA’, Brynmor Jones Library; John Sheldrake, ‘The LCC hospital service’, in Andrew Saint (ed.), *Politics and the people of London*, London, Hambleton Press, 1989, p. 189; Honigsbaum, op. cit., note 2 above, p. 328; Webster, op. cit., note 28 above, p. 6; SMA archive DSM 1/1, *Fourth annual general meeting of the Socialist Medical Association: executive committee report*, 1934, Brynmor Jones Library.

³² *Br. med. J.*, 1933, ii: 356. For subsequent developments in this area see, for example, *London County Council annual report 1937*, London, LCC, 1938, vol. 3, pt 2, and, more sceptically, Malcolm

Richardson, ‘Education and politics between the wars’, in Saint, op. cit., note 31 above, p. 159; Webster, op. cit., note 2 above, pp. 190–2; London Labour Party Health Research Group, *The public health of London*, London Labour Publications, 1934.

³³ Honigsbaum, op. cit., note 2 above, pp. 257, 206.

³⁴ *Lancet*, 1934, i: 1136, and 1933, i: 1324.

³⁵ Webster, op. cit., note 28 above, p. 18; the Labour Party Advisory Committee on Public Health, *The organisation of the preventative and curative medical services and hospital and laboratory systems under a ministry of health*, London, Labour Party, 1921, pp. 2, 5.

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all the health activities in a county or county borough—including the school medical service and the medical section of National Health Insurance—to the supervision of the public health committee of that area.

Such committees would already have taken over Poor Law infirmaries, and be free of any pauper taint. The advantage of this would be the “close association of all the [health] activities and the provision of staff to serve more than one department”. This form of organization, drawing heavily on the LCC experience, had been anticipated in 1932. Then Hastings had suggested that a useful first step would be to “constitute the Counties and County Boroughs as the sole administrative units for health purposes”; the second step would be to “make a new authority representing both county and included County Boroughs the unit”.³⁶

Before 1939 the details might have been imprecise, but the principle of local, democratic control was clearly important. It allowed doctors to pursue legitimate medical ends without unwarranted interference. This is not to say that no central body was to exist. Hastings found the brief of the Ministry of Health unsatisfactory in that it did not include matters such as the medical inspection and treatment of schoolchildren. It was necessary to “transfer all the public medical activities of the nation to the Ministry of Health”, but simultaneously to transfer them “locally to Public Health Committees”.³⁷ As an efficiency measure, health at a national level should be rationalized and brought under the control of one national body, but the key unit was the Public Health Committee. The model of health service structure proposed by Hastings was thus local, democratic and firmly in the tradition of municipal control over welfare matters, while allowing for a measure of central co-ordination. Fox’s ascription to Hastings and the SMA of “hierarchical regionalism” therefore needs qualifying. Fox correctly highlighted certain centralizing tendencies in SMA thinking on health organization.³⁸ Hastings on occasion did use the expression “regional”, thereby implying a more remote and centralized version, and, as has been shown, he was at pains to emphasize the primacy of professional knowledge. But the idea of building a health service on local government foundations was central to his thinking. In part this was because such a model had an established historical pedigree; in part because Hastings repeatedly emphasized democracy and citizen rights.

Given the complex and overlapping nature of existing services, medical organization was a recurring preoccupation of Hastings. The creation of a state medical service meant a better deal for more patients; an end to class discrimination; democratic control and rational planning; an environment in which doctors could carry out their professional duties while not being allowed to play medical politics; collective rather than individual provision; an emphasis on preventive medicine, and efficiency, including the effective and responsible use of money.

The Nation’s Health

There was more to Hastings’ politico-medical philosophy than simply organizational matters. With his Christian and socialist values, Hastings was appalled by the condition of

³⁶ Hastings, *op. cit.*, note 9 above, p. 5, and *op. cit.*, note 11 above, p. 20.

³⁷ Hastings, *op. cit.*, note 11 above, pp. 14–15.

³⁸ Daniel M Fox, *Health policies, health politics: British and American experience, 1911–1965*, Princeton University Press, 1986, pp. 56–60.

inter-war Britain. It was clear that, in the aftermath of the collapse of the second Labour government and the onset of intense economic depression, millions were without the necessities of life; industrialists were taking the opportunity to force wages down and, consequently, the standard of life was being lowered below that needed to “maintain health and efficiency”. Given the possible damage to the national stock, it was “the height of folly . . . to reduce the necessary food allowance of any household”. Cuts in social services had potentially disastrous consequences for national health. Hastings told the Commons that while much time had been devoted to the Gold Standard, “the man standard” was of even greater importance. The nation could not afford to neglect anything which would help maintain this at the highest possible level. Both employed and unemployed had to be at the “highest standard of fitness”, not least because of Britain’s role as a trading nation. Hastings insisted that existing welfare provision was inadequate. Families dependent entirely on unemployment benefit or public assistance already faced health problems, since such benefits were “insufficient to keep their recipients in physiological health”. Overall, Hastings claimed in 1930, premature death and ill-health were costing the nation nearly £300,000,000 annually.³⁹ Health was thus important for economic as well as for humanitarian reasons.

Like others in the Labour movement, Hastings’ conviction that the nation’s health was in a poor state—and probably deteriorating as a result of various forms of social deprivation—led him to be highly sceptical of official statistics. At a meeting in 1936 organized by the Committee Against Malnutrition, he suggested that official data on the distressed areas be “taken with a grain of salt, for they do no more than interpret the mind of the party in power”.⁴⁰ In contrast to such official misinformation, the physical effects resulting from insufficient quantities of the right type of food were “obvious to all”. Hastings’ concern with national health was most clearly manifested in what he saw as a central politico-medical concern—child welfare. After his 1931 visit, he contrasted Russian children and “the pitiful little objects one sees in many of the larger towns of Britain”. Hastings attributed this in part to the apparently extensive Soviet child and maternal welfare system. Child ill-health had a very clear class dimension. It was surely the case, Hastings argued in 1923, that working-class children were “not really getting a fair chance?”. A Labour government would stop “the systematic starvation of the children”. Discussing in 1933 the proposals of the then Conservative LCC for economy measures in health provision, Hastings found these instituted a “class war” against working-class living standards. In the last resort, temporary measures such as school meals were fine, but “the real cause of poverty is capitalism”.⁴¹

In his maiden speech in the Commons, Hastings claimed the nation’s children “as the most important capital we can possess”. Social service cuts resulting in injury or loss to

³⁹ Somerville Hastings, ‘The building of an A. I. nation: we must begin with the children’, *Labour Woman*, July 1934, p. 104; *idem*, *Fabian tract no. 241: A national physiological minimum*, London, Fabian Society, 1934, pp. 3, 4; *Parliamentary debates 5th series, 1930–31*, vol. 57, cols. 87–8; *Lancet*, 1932, ii: 1185; Hastings, *op. cit.*, note 7 above, p. 543.

⁴⁰ Quoted in Margaret Mitchell, ‘The effects of

unemployment on the social condition of women and children in the 1930s’, *History Workshop*, spring 1985: 105–27, p. 112.

⁴¹ Hastings, *Medicine in Soviet Russia*, *op. cit.*, note 5 above, pp. 11–12; *idem*, *Labour, the children’s champion*, London, TUC and Labour Party, 1923, p. 3; *London News*, April 1933, p. 7, and Oct. 1933, p. 8.

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this “valuable capital” violated principles of “sound finance”.⁴² Any damage done to children was, effectively, damage to future generations. A strong case could be made for medical inspection and treatment being extended to pre-school children. If impaired on reaching school, “the mischief is . . . already done and cannot be undone”, and consequent efficiency irrevocably damaged. Exposure to malnourishment made “a permanent scar on the constitution of a child”. Furthermore, malnutrition was notoriously difficult to detect by physical examination, as Hastings knew from his own and from LCC surveys. Malnutrition might be relative to the position of the observer, while the apparent comfort of the home was also an inaccurate indicator since families which endeavoured to keep their children well-clothed might be doing so at the expense of essential, but relatively expensive, foods. To remedy this, at least for future generations, the first requirement was an adequate diet. Hastings was convinced that the child who did not get the proper food from birth until growth was complete could “never grow up to be the man or woman he [sic] was intended to be”. The article from which this came was, significantly, entitled ‘The building of an A.I. nation: we must begin with the children’.⁴³ The physical ill-health of children was, therefore, a matter of profound economic and social importance.

There were also other potential dangers for the nation. Lack of proper food had more than physical consequences. In the early 1920s, Hastings had noted that child malnourishment might also result in “mental slowness”.⁴⁴ In 1934, reviewing the arguments for a “national physiological minimum”, he suggested that the contemporary “mass hysteria” of German youth might be partly due “to the mental and psychological effects of underfeeding during the war”. In an era of fascism and dictatorship, when the Labour movement was looking apprehensively at events abroad, the meaning was clear. Badly nourished children not only carried the physical effects for the rest of their lives, to the detriment of efficiency, but might also become prey to anti-democratic ideas. Since for the Labour movement democracy and socialism had become virtually synonymous terms by the 1930s, this was deeply disturbing. Children, and thereby future adults, had to be saved and their health guaranteed, otherwise the political consequences would be dire. Others on the left picked up this point. The SMA journal *Medicine Today and Tomorrow*, for example, suggested in 1937 that if “we value the future [children] should be given everything they require to make them healthy citizens . . . The dictators know that children are all-important. Can the democracies afford to fall behind?”⁴⁵

On a basic level, and reflecting the concern of a wide range of medical and social reformers, Hastings sought legislation for the provision of good quality milk to all children who needed it. As he explained, this was because of the proteins, fats and carbohydrates which milk provided, as well as the assistance it gave to other foods, such as cereals and vegetables, in providing proteins. Initially, Hastings seems to have found vitamins rather more problematic, suggesting that they should not be a matter of concern, not least because

⁴² *Parliamentary debates 5th series*, 1924, vol. 169, col. 1907.

⁴³ Somerville Hastings, ‘The future of medical practice in England’, *Lancet*, 1928, i: 67–9; *Lancet*, 1933, i: 661–2; *London News*, Sept. 1933, p. 8; Hastings, ‘The building of an A.I. nation’, op. cit., note 39 above,

p. 104; *idem*, *Fabian tract*, op. cit., note 39 above, p. 7.

⁴⁴ Hastings, op. cit., note 41 above, p. 8.

⁴⁵ Somerville Hastings, ‘Food and health’, *Labour Woman*, June 1936, p. 88; *idem*, *Fabian tract*, op. cit., note 39 above, p. 8; *Medicine Today and Tomorrow*, Nov. 1937, no. 2, p. 13.

it was possible to have “bad effects from excess of vitamins as well as from a deficiency”. Milk, green vegetables and fruit were sufficient for most children’s needs. But in time he found vitamins of “fundamental importance”, recommending the above diet plus cod liver oil to pregnant women, nursing mothers and growing children.⁴⁶

Overall, however, Hastings’ analysis of child health rested on more than just a good diet. What was desired was not just healthy children, but “children . . . kept in the very best health”, so schools were among the most important deliverers of health care. In a passage from a multi-authored publication, but certainly written by Hastings, he demanded that the school medical service form “an integral part of the public health department”. This was to be supervised overall by the MOH, with a specially qualified school medical officer responsible for the system’s immediate running. Facilities were to be improved, not least for pre- and immediately post-school children. Inspections were to be carried out more frequently than at present, and to be longer and more thorough. Most significantly of all, fees “charged to parents for medical treatment should be abolished”. Because of ill-health, many children were unable to benefit from state education. It was therefore the duty of the state to remove this impediment, “and to allow no financial consideration to interfere with the efficient education of its future citizens”.⁴⁷ Organizationally, this brought together a number of familiar themes: the role of the local public health authority, not least in the integrating of existing services; and more thorough, and free, inspection and treatment.

This was to be backed up by a much-enhanced school meals service. He attributed the decline in child health to inadequate levels of school meal provision. As part of a “national policy of nutrition”, free milk and, ultimately, free school meals for all children should become “part of the ordinary school routine”. Moreover, children of different ages had different needs, and Hastings berated those public assistance authorities which operated a scale of relief solely according to the number of children. This was “physiologically absurd” because of the implicit assumption that all age groups had the same nutritional requirements. Should a child fall sick, the Labour Party demanded “free doctoring for all”, with the state providing “everything necessary” to effect a cure. A “first class” doctor should be available for home visits if needed; should be able to “order nourishment as well as medicine when this is required”; and have the power to arrange hospital and convalescent home admissions. Such medical reforms were the “birthright . . . of every child”, something recognized only by Labour.⁴⁸ Hastings saw children as the building blocks of national health, and thereby of political and economic health. The child medical services should be an exemplar of the health care to be made available to the whole population, and such services should be fully integrated and planned.

Planning was an obsession of the 1930s,⁴⁹ and appealed to the socialist and the professional sides of Hastings’ character. There is a strong sense in his article on the Soviet Union that, despite misgivings about the political system and certain aspects of health care

⁴⁶ Hastings, *op. cit.*, note 41 above, p. 8; *idem*, *op. cit.*, note 39 above, pp. 104, 109; *idem*, *op. cit.*, note 45 above, pp. 88, 89.

⁴⁷ Hastings, ‘The building of an A.I. nation’, *op. cit.*, note 39 above, p.104; Barbara Drake (ed.), *State education*, London, Victor Gollancz/New Fabian Research Bureau, 1937, pp. 39–42.

⁴⁸ Drake, *ibid.*, pp. 46–7; Hastings, *Fabian tract*, *op. cit.*, note 39 above, p. 10; *idem*, *op. cit.*, note 41 above, p. 11.

⁴⁹ See especially Arthur Marwick, ‘Middle opinion in the thirties: planning, progress and political agreement’, *Eng. hist. Rev.*, 1964, 79(2): 285–98.

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(which he frequently attributed to the Russian “character”), he admired what he saw as its integrated and comprehensive nature. For this was the core of Hastings’ vision: a health service where all functions revolved around one focal point, and where the anarchy, overlap and class discrimination of the existing British system was done away with. In its place would come a free and comprehensive state system where health professionals, specialists in an ever more specialized world, could get on with their work. Of course in a democracy, safeguards against professional self-interest were needed, and the local and democratic bases of the health services were to provide the necessary controls.

Conclusion

It is clear that in several strategic ways Hastings’ aims were fulfilled by the post-Second World War legislation, since the NHS went a long way towards creating a free and comprehensive service. Equally, it did little to encourage other central elements in Hastings’ vision: health centres were neglected; the NHS was organized in a way which effectively ignored the claims of local government and local democracy; and the post-war political settlement made concessions to the medical profession which ensured a high and continuing level of autonomy, free from any real measure of democratic control. As Murray pointed out, the SMA in 1946 accepted the National Health Service Act as a “great step forward”, but also concerned itself with “what had *not* been achieved” (original emphasis). This was a “formidable list” and included a number of points on which Hastings had long campaigned.⁵⁰ In this context it is worth noting that Aneurin Bevan distanced himself from the SMA and sidestepped certain of its key demands. This led Honigsbaum to see the 1940s as an era of “defeat” for the organization.⁵¹

Hastings’ period of greatest influence had begun earlier when he led the SMA contingent on the BMA Planning Commission, a matter of some concern among ordinary BMA members. Similarly during the war, Hastings and his organization seemed to have a significant impact on Labour Party policy, particularly by virtue of their influence on the Public Health Advisory Committee, of which Hastings was chairman.⁵² Hastings’ diligent and painstaking work in the inter-war period had clearly increased his status in wartime medical politics. Such was his confidence that, addressing the British Federation of Social Workers in 1943, Hastings suggested that the boundaries between health and other professionals would soon break down; that the “unified health service” would be much more concerned with prevention; and that the “two foci of the personal health services will be the hospital and the health centre”. In late 1948 he claimed that the NHS was “in most ways a direct outcome of SMA policy”, and that the organization could congratulate itself on this. Hastings’ optimism was at odds with the scepticism of other SMA members. H H MacWilliam, author of the influential pre-war Walton Plan, suggested early in 1948 that blame for the current difficult situation could not rest entirely with the BMA. Bevan could be criticized in many areas, administrative and political, but his greatest error was “his failure to appreciate the importance of Health Centres”. The dropping of these had made

⁵⁰ Murray, *op. cit.*, note 1 above, p. 85.

⁵¹ Webster, *op. cit.*, note 28 above, p. 79;
Honigsbaum *op. cit.*, note 2 above, p. 253ff; *idem*,

Health, happiness and security, London, Routledge, 1989, pp. 95–6.

⁵² Honigsbaum, *op. cit.*, note 2 above, pp. 281–2;
Stephen Brooke, *op. cit.*, note 2 above p. 137ff.

the service inferior to what it might have been, as well as destroying its attractiveness to many doctors.⁵³

The imperfect fit between Hastings' and the SMA's aspirations and the emergence of the NHS became evident in Hastings' statements in the 1950s. Contrary to his previous claims, in 1953 he suggested that where Bevan had gone wrong in framing the 1946 Act was in failing to "take the advice that we offered him", especially in respect of "a full-time service for doctors and the complete unification of the different branches of preventive and curative medicine". In the early 1960s Hastings acknowledged the SMA's successes, but suggested that to achieve its aims it still had "a long way to go". The NHS was deservedly popular, but in many respects had been deficient from the outset because it had sought to accommodate conflicting interests. A push still had to be made for a service "unified and integrated, free and open to all and carried out by whole-time doctors from hospitals and health centres. Nothing less will secure the ideals for which the SMA has always stood".⁵⁴

Hastings therefore moved away from an early, optimistic position on the NHS to one of qualified scepticism. In the area of medical organization, Hastings' ideas showed a trajectory from at least partial acceptance of Bevan's plan in the 1940s to a return to traditional SMA ideas by the 1950s. During the 1946 Bill's second reading, Hastings argued that Bevan had shown quite clearly the impossibility of leaving "the new hospital service in the hands of either the voluntary or municipal hospital authorities". As a whole it was, he suggested at the time, a "very great Bill", a "masterpiece of political strategy". By the early 1950s, however, he was suggesting that serious issues had to be addressed concerning the health service's future direction. Not least among these was democratic local control, a "basic conception if health worker and citizen are to be united in the fight against disease". The near future should see a move from the "tentative beginnings" of the NHS to the "full operation of a truly socialist scheme". Further elaborating his views on the question of NHS re-organization, he suggested that the issue of local government reform was central. No political party had so far dared to attempt this, but the issue had to be addressed.⁵⁵ Localism had reasserted itself in Hastings' thoughts on health service organization.

Other areas of pre-war concern also remained important. Hastings was a member of the Curtis Committee on Child Care, which reported in 1948, and of the LCC's Children Committee set up in the wake of the 1948 Children Act. Child cruelty was mostly attributable, he thought, to "weakness of character, ignorance or ill-health". Parental responsibility should be strengthened, if necessary by the state providing compulsory retraining facilities for parents.⁵⁶ Discussing the plight of German children in 1947, he

⁵³ Somerville Hastings, 'The social worker in the unified health service', *Medicine Today and Tomorrow*, 1943, 4(3): 11–13; 'International Socialist Medical Association', *Medicine Today and Tomorrow*, 1948, 6(7): 3–10, p. 4; Henry H MacWilliam, 'For the record', *Medicine Today and Tomorrow*, 1948, 6(5): 3–8, p. 8.

⁵⁴ Somerville Hastings, 'New ideas for health administration', *Medicine Today and Tomorrow*, 1953, 9(4): 4–7, p. 4; *idem*, 'The Socialist Medical Association and its achievements', *Medicine Today and Tomorrow*, 1960, 12(7): 10–12, pp. 10, 11, 12; 'Now for the general election!', *Medicine Today and*

Tomorrow, 1964, 16(2): 8–14, p. 8.

⁵⁵ *Parliamentary debates 5th series*, 1945–6, vol. 422, col. 275, and vol. 246, col. 450; Somerville Hastings, 'Those sixty-six million pounds', *Medicine Today and Tomorrow*, 1946, 5(6): 4–5, p. 4; 'The next five years in health', *Medicine Today and Tomorrow*, 1951, 8(2): 3–9, pp. 3, 4, 9; Hastings, *op. cit.*, note 53 above, pp. 6–7.

⁵⁶ 'Since the Curtis report: some reflections by members of the Care of Children (Curtis) Committee', *Child Care: quarterly Review of the National Council of Associated Children's Homes*, 1957, 11(4): 131–3, p. 132.

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repeated his claim that child malnourishment had been instrumental in making an earlier generation susceptible to Nazism. As to British children, since 1945 they had experienced a “really extraordinary” improvement in health. Furthermore, they remained vital to society, not least because of the ageing population.⁵⁷ Hastings therefore continued to see children as crucial to the nation’s development. More generally, health was, he told Sir Keith Joseph during a Commons debate, more important than education, not least because a nation’s productive capacity and welfare depended on the mental and physical health of “the majority of its citizens”.⁵⁸ There was therefore a strong element of continuity at the heart of Hastings’ pre- and post-Second World War analyses.

How then should we place Hastings in the inter-war period, when crucial aspects of his thinking on medical politics began to take shape? He was instrumental in setting up, and leading, the SMA. Equally, from his election in 1932 Hastings was a key figure on the LCC, which in turn had a significant role in the wider Labour movement, and he was an MP during the two Labour governments. He also served on bodies such the advisory Committee on Public Health which was influential in the early 1920s;⁵⁹ and again when it was reactivated in 1938, at Hastings’ instigation and under his chairmanship. Hastings was also extremely vigorous in propagating his ideas through journal and newspaper articles, and public speeches.

But this impression of an individual at the centre of policy making and health innovation must be qualified. As Fox points out, the SMA was notable in being virtually the only medical organization ignored by the Political and Economic Planning Health Group in compiling their influential report of 1937.⁶⁰ As far as Hastings himself was concerned, the limitations of his position manifested themselves in a number of ways. Rousing and well-received as his speech to the 1932 Labour Party conference undoubtedly was, the following year he had to ask why his resolution had not yet been discussed by the National Executive. Herbert Morrison replied that it had been a busy year. As Marwick suggests, the resolution eventually adopted in 1934 was striking for the “extreme caution with which it was phrased”. The following year an SMA resolution on school feeding was not brought forward to conference. Many resolutions never see the light of conference day but, given Labour’s supposed concern with this issue, and the absence of any similar resolution the same year, this was a setback for the SMA.⁶¹ Just as telling, Hastings’ *The people’s health* came with the rider that it was “not in any way a statement of official Labour Party policy, and has not been examined or approved by the Labour Party as such”. The document was subsequently modified before appearing as *A socialized medical service*. The lack of any real debate on the issue of health services at party conferences suggests the irrelevance of such modifications.⁶²

⁵⁷ *Parliamentary debates 5th series*, 1946–7, vol. 433, col. 2493; 1948–9, vol. 470, col. 2933; 1947–8, vol. 450, col. 1627.

⁵⁸ *Parliamentary debates 5th series*, 1957–8, vol. 585, cols. 58–9.

⁵⁹ Marwick, *op. cit.*, note 2 above, p. 389;

Murray, *op. cit.*, note 1 above, p. 15.

⁶⁰ Fox, *op. cit.*, note 38 above, p. 65.

⁶¹ *Report of the thirty-third annual conference of*

the Labour Party, London, Labour Party, 1933, p. 141; Marwick, *op. cit.*, note 2 above, p. 396; SMA archive DSM 1/1, *Report of the executive committee, 1935–6*, Brynmor Jones Library. Hastings was again the SMA conference delegate.

⁶² Hastings, *op. cit.*, note 11 above, p. 2; SMA, *A socialised medical service*, London SMA, 1933; Murray, *op. cit.*, note 1 above, p. 26.

In a broader context, Hastings was not the only advocate of medical reform between the wars. A number of his proposals, most notably for a salaried medical profession; for a free and comprehensive service; and for an end to the panel system, were undoubtedly radical and far-sighted. But there were also areas of common ground with other reformers. Fox overstates the notion of consensus between organizations such as the SMA and the BMA, not least because of the former's demand for a changed relationship between doctor and state.⁶³ But it was the case that other, more powerful, organizations, committees and individuals were coming to terms with the need for radical changes in health provision. The Dawson Report of 1920 sought to protect the general practitioner and the panel system and argued against a state salaried service, but it also acknowledged the need for medical reorganization, for health centres and for considerably greater co-ordination and co-operation between services. Dawson himself recognised that greater state intervention in medical affairs was virtually inevitable.⁶⁴ PEP Health Group's influential report on health suggested greater co-ordination among the medical services while advocating the expansion of the panel system.⁶⁵ The Sankey Commission recommended the regional organization of hospitals, while stressing the continuing need for voluntary as well as public hospitals. The BMA too jumped on the reforming bandwagon. In *A general medical service for the nation* a state medical service was rejected and an expanded panel system called for, while it was accepted that a reorganization of medical services was badly needed.⁶⁶ Thus Hastings must be seen in context alongside other health reformers. It is significant that his most radical proposals were *precisely* those which his more powerful and influential rivals sought to distance themselves from, not least because of their unpopularity with the majority of medical practitioners.

This is not to diminish his influence on the political Left, which was clearly profound and which was shown by his role in the early 1940s. None the less, the dynamic Hastings did not have things all his own way, and for the following reasons. First, there were differences of emphasis within the Labour movement as to the correct balance between reshaping the economy and carrying out social reform. If planning was one of the preoccupations of the pre-Second World War era, then for many in the Labour movement this meant economic planning. Rational control of the country's economic affairs, it was argued, was the first priority of any incoming socialist government, and this could mean that social reform would have to take a back seat, not least because of the need for fiscal responsibility. With an economy run on rational lines, the remedial measures proposed by welfare reformers such as Hastings would be much less necessary, as rising incomes would do away with the worst aspects of working-class life. This was the classic social democratic dilemma, and in the 1930s Hastings' views might have been construed by the more influential sections of the party as interesting but unattainable or even utopian in the short term. Eckstein correctly highlights the problems of Labour ideology in respect of health prior to 1939.⁶⁷

⁶³ Fox, *op. cit.*, note 38 above, p. 56.

⁶⁴ Honigsbaum, *op. cit.*, note 2 above, p. 64ff; Webster, *op. cit.*, note 28 above, p. 19; Fox, *op. cit.*, note 38 above, pp. 28–9.

⁶⁵ Fox, *op. cit.*, note 38 above, pp. 64–9.

⁶⁶ British Medical Association, *A general medical*

service for the nation, London, BMA, 1938; Abel-Smith, *op. cit.*, note 19 above, p. 412ff.

⁶⁷ H Eckstein, *The English health service: its origins, structure and achievements*, Cambridge, Mass., Harvard University Press, 1958, p. 102ff.

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Secondly, on a practical level Hastings' arguments did not always win acceptance. Part of the reason for his enthusiasm to reactivate the Public Health Advisory Committee in 1938 was SMA concern over acceptance by important sections of the Labour movement of parts of the BMA's rival proposals for a future health service, especially regarding health insurance and maternity provision.⁶⁸ Thirdly, it was also significant that the SMA, into which Hastings put so much of his energy, was on the Left of the movement, something not approved of by the Labour leadership. The SMA supported the leftist Stafford Cripps, was prepared to set up its own version of the Popular Front by allowing Communists as members, and was involved, indeed played an active role, in left-wing bodies such as the Spanish Medical Aid Committee, of which Hastings was vice-Chairman.⁶⁹ Fourthly, in the wider context of health reform, Hastings' was one of a number of voices, with his rivals in certain cases having greater organizational and political influence.

By 1939 Hastings had established himself in a position of limited political power and had put forward an increasingly comprehensive and coherent range of proposals for a socialized medical service. In practical terms, he had played a central role in setting up the SMA and in leading the health service provision of the nation's most important and influential city, London. This underpinned his reputation in the 1940s. But other factors were to work against the Labour Party's wholesale adoption of Hastings' proposals. Initially, he was prepared to welcome wholeheartedly Bevan's scheme, perhaps not least because of its abolition of the sale of practices, something he found particularly objectionable. But Bevan, for a range of reasons, introduced what Hastings and many of his colleagues came to see as a top-heavy, centralized and yet still fragmented system. In the post-war environment Hastings' original vision of a co-ordinated and integrated service, with built-in elements of local control, did not prove politically possible. As the behaviour of the BMA in the post-war period demonstrated, his scepticism about the medical profession was well-founded, just as his belief that all doctors would ultimately participate in, and only in, a full state service was over-optimistic. Furthermore, the social democratic dilemma over which should come first: economic planning and growth, or wholesale social service provision, remained unresolved. This might be seen as contributing to a number of the NHS's early problems. Hastings' inter-war ideas, therefore, focused on some of the central issues in health service provision, but his blueprints for reform provided answers which, in their entirety, have yet to find political acceptability.

⁶⁸ Hastings, *op. cit.*, note 9 above, p. 4; *idem*, *Medicine Today and Tomorrow*, July 1938, no. 10, p. 7.

⁶⁹ See the extensive correspondence in respect of Cripps in the SMA archive, Brynmor Jones Library; Honigsbaum, *op. cit.*, note 2 above, p. 258ff; Charles Brook, *op. cit.*, note 1 above, p. 11.