Before the NHS, British healthcare had no national system. While policies could be agreed and pursued by the Ministry of Health, the British Medical Association (BMA), the Institute of Hospital Almoners or any other national body, decision-making was distinctly local. For public hospitals this meant either the poor law union or the municipal authority. In the voluntary hospital sector, it was institutional. It is therefore only through investigation at the level of the hospital itself that we can really hope to gain insight into the uncomfortable accommodation between payment and philanthropy that emerged in the early twentieth century. As sites of charity, sites of care and sites of decision-making, these institutions were independent, although they did not operate in isolation. Context is important, and this means understanding the local economic, political and social context as well as the health and welfare sector within which the hospital operated.

Our case study is the city of Bristol, sitting within the historic county of Gloucestershire, on the border with Somerset, in the South West of England (see figure 2.1). In the mid-eighteenth century this port city, although slightly smaller than Edinburgh and far smaller than London, had been the largest of England’s provincial towns and cities, before the rapid growth of manufacturing centres in the Midlands and the North. While the early twentieth century saw Birmingham overtake Liverpool and Manchester to become England’s second most populous city behind London, Bristol’s steady growth has seen it remain seventh from the mid-nineteenth century behind Leeds and Sheffield; smaller than the major Scottish cities of Glasgow and Edinburgh but larger than nearby Cardiff or any other Welsh city. The importance of Bristol lies less in its role as regional centre
of population – which grew to over 400,000 in the later interwar years – and more with its economic and cultural significance as a major site of imperial trade, including famously the slave trade. Although it was not without some deep and highly visible social problems, the city's
trading wealth furnished it with hospitals and numerous other philanthropic efforts in response.

Bristol’s hospitals played an important role both within and beyond the city boundaries, providing medical education and specialist services for the South West of England. In this Bristol served as a regional capital, a key aspect of the ‘hierarchical regionalism’ Daniel Fox has suggested was characteristic of healthcare over the twentieth century. Before surveying the city’s hospitals, however, we should put them in their local context. In particular, we should locate them within the city’s mixed economy of welfare and the characteristics of the city that forged that mix. Indeed, the diversity and plurality of welfare provision in Britain’s past was especially evident in the case of Bristol. The absence of ‘gas and water’ socialism – with municipal control of utilities providing a bedrock – did not equate to a lack of provision in the city. Utilities, like other core services such as public transport, were provided by private companies. Meanwhile, charitable provision was extensive, including schools, settlements and almshouses, as well as dispensaries and hospitals. Consequently, Bristol was a city associated with philanthropists well-known in their day, such as Edward Colston, George Muller, Mary Carpenter and Hannah Moore. It might be expected that this left little space for public activity, and indeed this has been the charge of Alan DiGaentano. Yet the city was also home to the first Board of Guardians in England when the Bristol Corporation of the Poor was founded in 1696. From this early start, Bristol kept pace with the typical municipal developments of later centuries. Following wide-ranging sanitary reform in the mid-nineteenth century, municipal welfare activity underwent a notable expansion into the twentieth century. Bristol’s mixed economy of welfare therefore saw significant activity in all sectors.

This chapter will examine why the voluntary sector and wider mixed economies of healthcare, welfare and public services should be so well developed in Bristol. To do so, we will consider the social, economic and political factors at play in the city. Doing so allows to us ask what this meant for the hospitals operating in Bristol during the early twentieth century, which will be briefly surveyed. Embedding the wider picture in this local perspective is important if we are to understand what about the place and meaning of payment and philanthropy in the pre-NHS hospitals was due to the local factors and what was characteristic of British healthcare more widely.
Characteristics of the city

*Economy and wealth*

The foundation of Bristol's historic wealth, and consequent philanthropic dynamism, was trade. Its position as ‘a bustling gateway of empire trading’ in the eighteenth century is well known. However, a number of historians have begun to bring Bristol’s earlier trading history out from the shadows of its Atlantic heyday. The city’s geographical position afforded it earlier advantages in domestic trade as well, increasingly so as shipping, road and rail developments brought greater integration with the markets of England’s South East and Midlands, and then internationally. Equally, the city’s economic history since its eighteenth-century heyday has also undergone some revision, with focus moving away from early nineteenth-century failures in the private management of the city docks and Bristol’s subsequent usurpation by Liverpool and Glasgow. Amongst those offering a more positive assessment have been Charles Harvey and Jon Press:

> Bristol has not been home to many giant corporations nor has any single industry ever dominated the local economy, yet what the region has lacked in terms of size and specialisation has been more than compensated for in terms of industrial diversity and economic flexibility. The economy of the Bristol region may not have grown as rapidly as many others in the nineteenth and twentieth centuries, but nor has it suffered the traumas of retrenchment that lately has afflicted so many British towns and cities.

This trend whereby Bristol was economically well-suited to weather national trends can be seen from unemployment and poor law statistics up until the 1970s.

The city’s successful trading culture led to a sizeable and culturally active middle-class elite. When Charles Madge, co-founder of the Mass Observation movement, surveyed patterns of household saving in Bristol in 1940, he found 18.2 per cent to have weekly incomes above £7. This was notably more than the 12 per cent nationally with weekly incomes over £5, according to the Ministry of Labour in 1938. Meanwhile local surveys in both 1884 and 1937 concluded that, for the other four-fifths of Bristolians, living standards were high and death rates low. Figure 2.2 shows the 1937 income levels of the city’s working-class families, excluding the middle-class fifth of the population. 12.2 per
cent were living in a state of ‘comfort’, defined as those with incomes at least 200 per cent higher than the BMA’s harshly calculated minimum need. With an average gross income of 117s 6d per week, their lifestyle was described as ‘very comfortable by the prevailing standard of the classes covered’, allowing ‘a margin for holidays, savings and luxuries’. A further 56.8 per cent were said to be living in a state of ‘sufficiency’, with incomes ranging between 50 per cent and 200 per cent above the minimum and an average gross income of 75s 10d per week. This was described as ‘the ordinary standard of a Bristol working family’ with ‘some margin for saving or pleasure if they are frugal’. Another 20.8 per cent were said to live in a state of ‘insufficiency’, with an income above the minimum but less than 50 per cent above it, and an average gross income of 50s 2d per week. This was described as the ‘scanty means’ of those who ‘whilst not in poverty, have a hard struggle, and whose lot is far from comfortable’. The final 10.7 per cent were those with incomes below the survey’s calculated minimum needs, with an average gross income of 34s per week, and so deemed as ‘in poverty’.

While not without poverty, therefore, Bristol was a wealthy city.

Health and housing

The 1884 survey had emphasised that ‘With regard to health the inhabitants of Bristol are singularly favoured’. This was said to be a recent development, with the situation rather different before slum clearances and sanitary reforms had taken effect:

Then – not to speak of cellar dwellings and houses and rooms ill-built, out of repair, unventilated, with privies in sleeping and living rooms, and

![Figure 2.2 Working-class living standards in Bristol, 1937](image-url)
over-crowding – there were private drains, cesspools, sewers, ash and refuse heaps – (sometimes one of these last at the house door or the end of every court, and left to be removed at pleasure); unmade roads (‘not taken to’ by the authorities) in fairly populous parts of the town; public manure heaps; privies emptying into open ditches; open sewers discharging putrid animal matter into the river, often in the freshes left to decompose upon the meads; water (often no hard water obtainable) deficient and tainted. But now there are 150 miles of sewerage, not such a thing as an open ditch, all ejects are trapped, a constant system of inspection, scavengering, limewashing, disinfecting is vigorously at work, and a water supply which, though here and there it may be inadequate, and is unfortunately retained in private hands, and is not therefore under the control of the public authorities, is pure and good. 20

As sanitation was improved, death rates fell. 21 By 1883, Bristol had the lowest infant mortality rate (133 per 1,000 births) out of the twenty-eight large towns in England and was the only city with an overall death-rate below eighteen per 1,000. 22 In the early 1930s, a Ministry of Health report on the city noted that the death rate continued to be lower than the average for a county borough, despite recent epidemics of influenza and measles. 23 Beneath these low death rates, however, Bristol was home to notable health inequalities. This was evident from the geographical variation in mortality rates. In central areas it was 30 per cent higher than the city’s interwar mean. In Westbury-on-Trym, which saw the lowest of the lower rates across the city’s northern suburbs, it was 25 per cent below. There were exceptions, notably with a falling death rate from Congenital Debility and consistently lower infant and maternal mortality rates in the poor city centre. Hazlehurst attributes the latter to the movement in this period of the poorest families from central slums to new suburban corporation housing estates that were not as healthy as might have been expected. 24

Even with new housing estates, the 1931 census reported greater ‘housing pressure’ in Bristol than any other part of Gloucestershire. Some 80.37 per cent of the city’s occupied properties were home to a single family, while 16.18 per cent were home to two families and 3.45 per cent were home to three or more. Thirty-six per cent of families in Bristol shared their dwelling. The city-wide average was 1.25 families to each dwelling, with the rates for the nearby urban districts of Kingswood and Mangotsfield also high at 1.10 in both cases. 25 This reflected
the wider concentration of regional population in Bristol. The city was consistently home to half of the population in the Gloucestershire area as it grew over the early twentieth century.26 What emerges from an examination of housing, health and the economy is a picture of significant social problems within an otherwise prosperous and healthy city. ‘As a large, long-established city,’ Martin Gorsky has suggested, ‘Bristol can illustrate the concentration of needs which provided the demand for the voluntary sector and the emergence of the wealth which would finance the response to that demand.’27 Moreover, the concentration of population brought visibility to Bristol’s inequalities and social ills. In the words of one late-Victorian visitor to the city: ‘I doubt if such striking contrasts between the two great divisions of the human race – the haves and the haves-nots – are presented anywhere else so vividly as in Bristol.’28 Similarly, when in the mid-1870s volunteers from Clifton College arrived in St Agnes, a poor area just two miles from their public school, they found:

Muck-heaps and farm-refuse, on which jerry-builders had set up rows of houses, which periodically got flooded, and suck up fever and death from chill for the poor folk who lodged therein. No lamps. Streets only wadeable through. A few public-houses of the worst sort surrounded a bit of open ground which was called ‘the gardens’, in which were tumble-down low huts of squatters in old time. These dwellers were the pick of the neighbourhood.29

Riots and strikes
If the visibility of poverty was a prompt for social action, so too was the level of agitation and disorder in the city.30 Civil unrest has been a notable feature of Bristol’s history and one with the power to undermine the local ‘high-minded, well-ordered belief in progress’.31 The response to riots over a new Bridge tax in 1793 led the poet Samuel Taylor Coleridge to claim that, if it was a Bristolian virtue to shoot unarmed civilians, ‘I glory that I am an alien to your city.’32 A different perspective was offered by one critical commentator on a weekend of political riots by ‘Bristol mob-reformers’ in 1831, when it was said ‘the rioters were masters of the city.’33 A similar sense of lawlessness was characterised during the 1980 St Paul’s race riots by a police chief being heard to exclain: ‘Surely we should be advancing, not retreating?’34
Between these dramatic episodes, however, Bristol saw prolonged periods of calm, which were often out of step with the national mood, as had been the case when Bristol saw little of the chartist activity seen elsewhere. Our chronological focus covers the end of a period of high tension in the city, which had taken hold in the 1880s, with notable radicalisation around industrial matters, unemployment and poverty. Where the economic turbulence of earlier decades had been largely felt by the city’s small firms with un-unionised workers, things were different by the end of the nineteenth century. Traditionally, Bristol’s diversity was reflected in its series of small craft unions who saw their job as providing information to the public on matters relating to the local workers and poor. Following a politicisation oriented firmly towards the Liberal Party in the 1870s, there was an ‘upsurge of militancy’ and union membership, which saw ‘strike followed by strike in the city’. This unrest continued into the interwar years, as strike action was taken by dockers, seamen, gasworkers, miners and transport workers. Therefore the introduction of payment into the working-class experience of hospital treatment took place against a backdrop of social discord.

Following the First World War there were notable tensions around the situation of returning servicemen in three areas: public services, including the hospitals; public support, especially poor law relief; and unemployment alongside the continued employment of women. The position of ex-servicemen as patients in the Bristol Royal Infirmary was insecure, as seen when military patients were limited to 200 at any one time after a tense stand-off when 300 of them had refused to vacate their beds to make way for a venereal disease clinic in February 1919. Two years later the public postwar donation benefit paid to ex-servicemen was ended in favour of poor law unemployment relief. The poor law guardians’ offices were targeted in demonstrations, prompting an increase to the relief scales in September 1921. Meanwhile, ex-service-men especially suffered in a climate of ‘craft restrictions’ where vocational opportunities were severely limited. Discontent with female employment spilled over into a series of attacks on the city’s trams in April 1920, after which women were no longer employed to work on them. Although it had been suggested male workers might strike in solidarity with the female tram workers if dismissed, there appears to have been little appetite to put this into practice. Across the interwar period female employment in the city in fact varied greatly. It peaked
at 6,930 in December 1930, but from 1933 until the end of the decade it remained consistently low at between 1,500 and 2,000.44

The wider picture in the early 1920s was one of ‘exceptional militancy’, with protests and outbreaks of violence commonplace and allegations of brutality made against the police in 1921. However, strikes became something of a rarity after the demoralising resolution of the General Strike of 1926, in which 36,000 of Bristol’s workers became involved.45 The period of greatest militancy therefore came a decade before the period of greatest unemployment.

Electoral politics

Some explanation for this may be found in the co-ordination of the local labour movement, allowing for a rechanneling of efforts from protest to electoral politics. This was rather different from the late nineteenth century, when the city’s labour and socialist movement was more of a social one, complete with its songbooks and summer picnics, as well as public lectures from the likes of William Morris and ‘quiet talks by the way on intricacies of economics and sociology’.46 Between the election of the city’s first Labour councillors in 1887 and the outbreak of war in 1914, however, Duncan Tanner viewed Bristol’s to have been one of the two ‘most successful Labour organisations’ in the country, the other being Leicester. He attributed this to the strength, especially in the poorer east of the city, of the 600-strong Independent Labour Party (ILP).47 Thereafter the merger of the Trades Council with the Labour Party in 1919 is also significant, as is the 1921 foundation of the Bristol Unemployed Association, which had established a close working relationship with the Trades Council and links with Labour by the end of the decade.48 When the local parliamentary breakthrough came in 1923, Labour won the Bristol East and North seats, also taking Bristol South in 1929.49 Since 1945 Labour has usually held the majority of Bristol seats.

Figure 2.3 shows both the success of Labour in Westminster elections since 1945 and the earlier dominance of the Liberals, stretching from the 1830s to the 1920s. In local politics, however, the situation was very different. It was in fact the Tories and then Conservatives that had control of the city council from 1812 until 1904, suggesting there was little difference between the merchant oligarchy before the 1835 Municipal Corporations Act and the reformed chamber thereafter.50 An
Figure 2.3 Party distribution of MPs in Bristol since 1832
outright Liberal majority in 1904 was denied by Labour’s five council-
lors, while Conservative dominance of the Aldermanic bench contin-
ued. Although 1906 saw the Liberals increase their representation to
hold three of the city’s four seats in its landslide general election victory,
the same year also saw them lose their position as the largest party on
the council for another century. By 1925 Labour had increased its
number of councillors from five to eighteen out of the sixty-nine total,
and again to thirty-two in 1930. These successes and the parallel Liberal
struggles prompted the formation of an ‘anti-socialist’ alliance, with
Labour facing the Citizen Party in local elections between 1926 and
1973. This arrangement not only held off a Labour majority for a decade
but also ensured clear control of the council until 1945. Between 1945
and 2002, however, no period without a Labour majority lasted more
than three years.

As ‘a distinctly local reaction to the rise of the Labour Party’, the
Citizen Party was able to position itself as a localist rejection of the
nationalising agenda of Labour when in government at Westminster.
Their pamphlets and cartoons at the time of the 1947 local elections
portray the local party simply doing the bidding of a failing central
government. Despite this, we should also bear in mind that the city
had, in W.H. Ayles, leader of the Bristol ILP, a champion of ‘decentral-
ised municipal Socialism’, a philosophy put forward in his 1921 What a
Socialist Town Council Should Be. It would not be correct, however, to
solely explain the rise of municipalism in Bristol by the growth of the
Labour Party as a political force. This was a trend becoming established
in parallel to the foundation of Labour organisations in the city, as the
Liberals responded to the city’s radical tradition. Indeed, the remit of
the council had expanded from its ten committees in 1875, increasing
to twenty-three by 1915. This expansion asserted the place of public
provision as an essential element of an established and diverse mixed
economy in the city’s welfare and public services, to which we now turn.

The mixed economy of welfare

Poor law
The earliest pillar of Bristol’s mixed economy of welfare was the poor
law. As early as 1696 the city’s eighteen parishes and the ward of castle
precincts collaborated to bring about the Bristol Corporation of the Poor, the first Board of Guardians in England, with the city’s old mint serving as both administrative centre and workhouse. However, this did not equate to a high level of service. By 1831, there were 600 inmates in this crowded workhouse, with ten beds for fifty-eight girls and seventeen for seventy-eight boys. Following the 1834 Poor Law Amendment Act, the Bristol Corporation Union was joined by another two. These were the Clifton Union, covering the Gloucestershire suburbs to the north, and the Bedminster Union, serving the Somerset suburbs to the south. In 1844, the Clifton Union’s Pennywell Road workhouse was visited by an Assistant Poor Law Commissioner, who reported both workhouse and inmates to be ‘filthy and wretched’, with ‘men, women and children being indiscriminately herded together’. Associations with poverty and high mortality rates saw the name changed to Barton Regis in 1877, distinguishing it from the wealthy parish and desirable health resort of Clifton.

The three unions were amalgamated in 1898, following the 1894 Local Government Act. Their amalgamation allowed for greater ‘moral classification’, including separating out the ‘Deserving Aged’. By this time the new union had 2,357 inmates spread across four workhouses (Stapleton, Eastville, Bedminster and St Peter’s Hospital), and another (Southmead) was built in 1902. The early twentieth century did not only see the expansion of workhouses, but also new schemes. For example, in 1922 the Guardians began putting men receiving Unemployment Relief to work cultivating their land in Downend. The 1920s also saw the increasing use of emigration as a welfare policy in Bristol, most notably to Canada and Australia.

Philanthropy
The poor law was one of the two pillars of Victorian welfare. The other was philanthropy. The historic prominence of philanthropic associations in Bristol was acknowledged in a Ministry of Health report on the city in the 1930s:

The religious enthusiasm evoked by Whitfield and Wesley still to some extent remains ... Bristol is well served with charities and voluntary organisations, many of which are ecclesiastical in origin, and the City is especially fortunate in possessing a comparatively large number of
wealthy citizens who are at the same time generous benefactors where municipal interests are concerned.63

Foremost amongst these benefactors were the tobacco-magnate Wills family, who funded the landmark university buildings as well as supplying a string of presidents for and substantial donations to the city’s hospitals. Philanthropic work and municipal governance alike had a proud pedigree amongst the city’s merchants, reaching back to Edward Colston.64 Bristol as an international city was reflected in the campaigning activities of the Indian social reformer Rajah Rammohan Roy in the early nineteenth century, and the orphanages founded by George Muller, son of a Russian exciseman, later in the century.65 At the same time, these philanthropic activities provided social networks within which women were able to interact not only with each other but also with new areas of public life, such as politics. Best remembered is Mary Carpenter, for her Reformatory and Industrial Schools from the 1830s. However, the late nineteenth century saw these associations also provide a platform for more radical campaigns, such as Frances Power Cobbe’s for women’s property rights.66

Philanthropy was also a common activity of the city’s less prestigious, middle-class citizens.67 Over the 1870s and 1880s, for example, the St Agnes Workmen’s Club developed out of the Clifton College school mission-rooms. By the 1890s the mission had turned its ‘attention to the wants of the boys in the neighbourhood’, running summer camps and establishing a Boys’ Club. This provided activities including football, cricket, gymnastics and swimming, all intended to offer ‘the help and discipline of life that they needed’. Following which a Girls’ Club was started, running camps and classes in embroidery. The mission was understood to provide ‘the boys of Bristol’ with ‘an education’ through ‘contact with the life of a Public School’, whereby they ‘learnt something of the public spirit, the spirit de corps so essential to a true life’. Meanwhile, it showed ‘the boys of the School … quite another side of life’.68

Martin Gorsky has noted in his study of charity in nineteenth-century Bristol that:

societies and subscriber institutions provided a means of addressing social problems which neither market nor state could tackle, the former because the purchase of social insurance, good education and health care was beyond the means of many, and the latter because the broad range
of consensus for social spending obtained only for the extremes of disadvantage: lunacy, the destitute, the aged and infirm.69

Not only did the voluntary sector in the nineteenth century operate in a space the public and private sectors were incapable of filling, but it also made a different contribution to the social fabric of the city. Victorian philanthropy in Bristol was, as Gorsky has noted, ‘a relation between have and have-not’, and this cannot be said in the same way of the era’s municipal or commercial solutions to social problems.70 However, the city’s historians have not universally taken such a positive view of philanthropy. Mary Fissell emphasised the ‘factionalized nature of charity and relief in the city’, describing charitable acts in eighteenth-century Bristol as both an ‘expression of civic unity’ and an ‘articulation of social difference’.71 Helen Meller’s work on leisure examined how Bristol’s middle-class elite embarked on a Victorian mission to bring about a unifying culture of ‘social citizenship’ in the city. While she was less critical of the mission itself, she concluded that the vision remained ultimately unrealised.72 While philanthropy did not bring about social harmony or unity in Bristol, it was undoubtedly a major feature of the social life of the city.

**Municipal activity**

Although philanthropic activity was extensive in the city, it would be wrong to see it as a substitute for public provision. Municipal interventionism, in both economic and social fields, was evident in Bristol from the early to mid-nineteenth century. Following the 1831 riots there were calls for policing reform, and following legislation the city established a public constabulary in 1836.73 When an outbreak of cholera claimed 445 lives in 1849, the response was to establish the corporation’s sanitary committee in 1851.74 This signalled the adoption of the permissive 1848 Public Health Act, which included responsibility for the maintenance of streets and lighting alongside the introduction of a modern drainage system, designed to intercept sewage and prevent it from flowing into the harbour. It was a major function of the council, coming by the 1870s to account for more than half of its expenditure.75 However, this action did not entirely put an end to the problem, simply transporting the sewage to the banks of the River Avon, with inaction continuing to prevent a more comprehensive project for decades thereafter.76
Meanwhile, there were developments continuing in other areas of public provision. The public School Board took over the work of religious groups running fee-paying schools and Clifton College’s ragged school, working ‘among neglected boys’, which had reached over 18,000 pupils. There were also public developments in utilities. Amongst the late nineteenth-century municipal committees set up was the electricity committee, in 1884, with one of England’s earliest public power stations by 1893. However, public control of such provision was limited, allowing an 1891 Fabian pamphlet to critique:

Bristol is in many respects the most backward of English municipalities. Most important towns in England own their own waterworks: Bristol leaves this vital public service in the hands of a monopolist company earning a dividend of eight and a half per cent. Two-thirds of the gas consumers in the United Kingdom are supplied by municipal enterprise: Bristol depends for light on a company earning ten per cent. More than a quarter of the tramways in this country are owned by public authorities: Bristol allows private adventurers to earn five per cent. by running cars through the public streets. Birmingham, Manchester, Bradford and many other places keep all three of these public services under public control for public profit. Bristol enjoys the bad pre-eminence of being the largest provincial municipality which allows all three to remain in private hands for private advantage.

Housing might also have been added to this list, as the critique of the Council for not implementing the 1890 Housing of the Working Classes Act was heard from those first Labour councillors.

Private enterprise

If action was slower than many wanted from local government, there was significant activity from other sectors, including private enterprise, as can be seen from the case of private asylums. Dr Edward Long Fox opened the first at Cleve Hill in 1794, two years before the more famous York Retreat, before moving to Brislington House a decade later. As such, this private asylum for the treatment of an elite clientele was one of the first purpose-built institutions for the care of the insane in Britain. At the same time there were developments in the commercial provision of public services, such as the private Bristol Gas Light Company’s introduction of gas street lights to the city within a decade of London setting the precedent in 1810. Meanwhile, the 1846...
establishment of the private Water Works Company was a direct response to the poor water supply, and was consciously seen as part of the public health reforms of the city; although it was a source of contention and there were calls for municipalisation until improvements in the 1870s.\textsuperscript{83} Equally, the interwar years have been remembered as the ‘heyday’ of the city’s private transport system, with both trams, not yet affected by the wartime bombing of 1941, and the Bristol Tramways’ taxi service operating in the city, until the latter was made uneconomical by the growth of car ownership in 1932.\textsuperscript{84} This private provision of public services continued through the early twentieth century until, just like the voluntary hospitals, they were caught up in the sweeping nationalisations of the postwar Labour government.

The changing mix of public and private can also be seen in the field of general practice. The 1911 National Insurance Act had introduced the panel system, whereby compulsory insurance for workers in selected industries would provide access to a doctor when taken ill. This system expanded over the interwar period, when it came to cover the majority of the adult population, alongside a parallel growth in the still more profitable private practice.\textsuperscript{85} In the case of Bristol, we should note the prominence of Clifton as a location for general practice surgeries. In this one area were the surgeries of all the voluntary hospitals’ consultants and a significant minority of the GPs in the whole city. However, as table 2.1 shows, this concentration was actually in decline over the interwar years. Over the 1920s there was an increase in the number of GP surgeries in Clifton before nearly half this growth was reversed in the following decade. Across the city as a whole, there was a growth of one-fifth in the first decade, then a marginal increase in the second. There was a lessening of the concentration of the city’s general practice in Clifton over the interwar years.

<table>
<thead>
<tr>
<th>Year</th>
<th>Bristol</th>
<th>Clifton (%)</th>
<th>Bedminster (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1919</td>
<td>226</td>
<td>88</td>
<td>38.9</td>
</tr>
<tr>
<td>1930</td>
<td>274</td>
<td>102</td>
<td>37.2</td>
</tr>
<tr>
<td>1939</td>
<td>280</td>
<td>93</td>
<td>33.2</td>
</tr>
</tbody>
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Source: Wright’s and Kelly’s Directories for Bristol.
practitioners in this one elite area, and an expansion in other areas. These included the city’s suburbs in the north (such as Westbury-on-Trym) and the south (including Knowle), but was most prominent in working-class areas such as Bedminster. This was an area on the south of the river, home to much of the industry and many of the labourers associated with the city docks, and table 2.1 shows general practice growing in this part of Bristol, especially in the 1930s as the local economy was recovering.  

**Health and welfare**

Municipal provision in the wider field of health also expanded in this period. An interventionist approach might be expected under Labour, yet they did not chair the Health Committee until the end of the 1930s. For almost the entire interwar period the Chairman was Herbert John Maggs, a notable figure in the local Liberal Party. Maggs served as a St George and Central ward councilor from 1906, alderman from 1927 and mayor in 1932. In the early 1930s, a Ministry of Health report noted that he ‘has had an almost unbroken connection with the Health Committee since 1906 and he has been its Chairman for the last 10 years.’ Given the wide-ranging remit of the Health Committee, it allows us to reconsider the supposed Conservative domination of the Citizen Party in this area.

The eagerness for municipal expansion in this field can be seen from the case of nourishment grants. For some time these provisions, usually of milk, had been part of tubercular care in the city. The Health Committee unquestioningly adhered to the Tuberculosis Officer’s recommendations on who should receive them, and as a preventive measure this came to include many poor expectant and nursing mothers and infants. This raised a complaint from the Town Clerk, who said this fell beyond the powers granted by Local Government Board Regulations, declaring himself to be ‘of the opinion that the Corporation cannot legally make any payment in respect of food or nourishment to mothers or children.’ The disagreement was resolved the following year when the 1918 Maternity and Child Welfare Act granted local authorities exactly this power. The number of nourishment grants increased following the Act and again in the late 1920s, when an investigation into the increase found six out of seven applicants were unemployed. By the mid-1930s Bristol’s annual spend of around £3,000 on
milk grants was similar to those Dr Dorothy Taylor’s Ministry of Health study found in Reading, Chelmsford and Shoreditch, significantly less than Manchester, and notably greater than Gloucester, Leicester, Northampton, Woolwich or Barking. This is in line with overall spending on maternity and child welfare, which was middling nationally but behind only its wealthy neighbour of Bath in the South West. Once again, activity in this area was not restricted to one sector. In fact, the majority of municipal spending over the interwar years went on contracts for the voluntary Bristol Infant Welfare Association to provide mother and infant clinics across the city.

**Universalism**

Bristol’s history is then one of local readiness to take on new powers, sometimes even pre-empting their legal empowerment, and then to extend activities in various fields of social welfare. This was also evident ahead of the 1929 Local Government Act that nominally ended the poor law. The response from the Board of Guardians to the high rate of unemployment and hardship in the 1920s was often to ignore ‘the restrictive means test applied to indoor and outdoor relief’ in an effort ‘to ease suffering’. It was a grassroots administrative rejection of the Victorian notion of less eligibility and the creed of utilitarianism, moving instead ‘towards the incipient beginnings of universal and equitable relief which was to become a central tenet of the Welfare State’.

This universalism was symptomatic of a new age, one distinctly different from that of the poor law and Victorian philanthropy. The effect of this shift on charitable activity was certainly a concern of the Bristol Charity Organization Society (COS), who feared the 1906 Liberal Government’s reforms would make ‘Socialism … a real factor in the life of the community’. The impact of local and national welfare initiatives was seen in a dramatic fall of more than two-thirds in applications to the Bristol COS (or Civic League as it was renamed): from 1,234 in 1907 to only 378 in 1927. This trend was reversed over the 1930s, with the number of applicants steadily rising to over 2,000 in 1940. The continued increase during economic recovery can be explained by a move away from grants and loans in favour of services ‘not concerned with the actual giving of money’.

The League was better placed to meet local needs by providing advice on landlords and moneylenders as well...
as public and charitable sources of support. This was aided by opening offices in the new housing estates in Knowle West and Southmead, which provided over half the League’s cases by the 1940s. The work of the League in these new districts could sometimes hark back to its COS origins, such as the establishment of a ‘thrift club’ in Knowle West ‘to defeat the present system of purchasing everything possible on credit.’ The early 1940s, however, saw their focus settle on the areas that would be left for the voluntary sector in the age of the postwar welfare state. This included a register of homeless people and work on old people’s welfare, but most notably a wartime enquiry bureau and the longer-lasting ‘Citizen’s Friend’ scheme with its ‘Poor Man’s Lawyer Service.’

Welfare across the mixed economy

The charge DiGaetano has levelled at Bristol is that only municipal developments in the twentieth century rescued the city from a failed private/voluntary model of public services. This description does not fit a history of early interventions, even if followed up less extensively than elsewhere, and a genuinely dynamic mixed economy across many areas, including medical and social welfare. The areas where municipal activity was limited in the nineteenth century were those same areas where commercial and philanthropic activity was considerable. Moreover, this mix continued in the twentieth century as provision from all sides expanded. It was not until after the Second World War, as Martin Gorsky has noted, specifically citing Bristol’s hospitals, ‘that the role of charity in core services came to be considered inappropriate.’ At least until this time, the voluntary sector was part of the diverse and pluralistic tapestry of service providers that made up the city’s evolving mixed economy of welfare.

Voluntary hospitals

Within this mixed economy we find the city’s hospitals. While the voluntary hospitals were leading charitable institutions in their own right, they were also deeply embedded within local networks of care. By the 1930s, the social work functions of the almoners, principally securing financial support and after-care arrangements for patients, had brought the hospitals into closer partnership with a wide range of...
local organisations, ranging from the Rotary Club to the university settlements and the local *Times and Mirror* Relief Fund. In some cases almoners made arrangements with voluntary bodies focused on health, including the hospital contributory schemes, district nurses, ambulance corps and various local funds for surgical appliances, while others supported specific groups, such as crippled children, military families or those with disabilities. In other cases they collaborated with religious organisations, ranging from the Bristol Diocesan Moral Welfare Association and the Waifs and Strays Society to the Catholic Women's League. The hospitals worked with a host of public bodies, including the Unemployment Assistance Board and a variety of municipal committees including on education, health and housing, as well as institutions already bringing together public and voluntary welfare providers, such as Infant Welfare Centres. The voluntary hospitals had longstanding arrangements with partners as varied as central government committees and a regular ‘anonymous donor for help with Insulin’. 

Firmly entrenched as hubs at the centre of these local networks of care, and at the intersection of the mixed economy of welfare, were the hospitals themselves (see Figure 2.4).

**General hospitals**

‘An Infirmary at Bristol for the benefit of the poor sick’, one of the first outside London, took its first patients in December 1737 – seventeen men and seventeen women. Its foundation was in line with the ‘liberal ethos, in which Christianity and commerce neatly joined’, and ‘the city’s merchant elite’ were the base from which the institution was established; and the city’s deputy Controller of Customs, John Elbridge, conceived of the idea and became the Bristol Royal Infirmary’s (BRI) first treasurer. This tie with the city’s wealthy business community remained strong into the interwar period, with the ‘plutocratic benevolence’ of the industrialist Wills family, which provided both numerous presidents and significant financial donations to the BRI and other voluntary hospitals in the city. This was a notable enough feature for it to be joked in 1934 that the city had been relying on the old adage: ‘Where there’s a Wills, there’s a way.’ Certainly the BRI was an institution for which charitable donations large and small continued to be important – although the interwar years saw this decline from a majority to under one-third of ordinary income. Still, the BRI was notably
Figure 2.4 Hospitals in Bristol in the 1940s
an institution established and governed by the city’s elite long before it officially became the Bristol Royal Infirmary. The divisions within this elite, between Whigs and Tories and between Church and Dissent, were evident in late 1770s elections of the Infirmary’s governors, which were said to have a ‘strong political flavour’.114

Political divisions in the city added to the case for the founding of a second general hospital, opened in 1831 on the waterfront on the industrial south of the river.115 This industrial setting meant that, alongside the patronage of the Wills family, the Bristol General Hospital (BGH) benefited from workpeople’s donations at a rate proportionately three times higher than the BRI.116 Beyond concerns one hospital could not meet existing demand, there was also desire for a politically different kind of institution.117 The city’s two sitting Whig members of parliament were heavily associated with the new hospital, as was George Thomas of the influential local family of Liberal Quakers.118 The new hospital was founded amidst the city’s Reform riots, and ‘it was said that patients going to the Infirmary would receive a sovereign remedy, but those at the Hospital a radical cure’.119 These differences were overcome when, in a gradual process between 1939 and 1942, the former’s 425 beds and the latter’s 269 were merged to form the Bristol Royal Hospital. Between them and then combined, they provided a major regional centre. Although nearly three-quarters of BRI patients were from Bristol, notable numbers came from further afield – one in ten patients was from Somerset and slightly more from Gloucestershire.120 The position of Bristol and specifically the BRI as the regional centre was reinforced when it became the site for the consolidated Bristol Medical and Surgical School, making the institution the South West hub for specialist services and training.121 By the Second World War 45.5 per cent of its beds were set aside for specialist treatments, with maternity, ear, nose and throat (ENT), orthopaedic and gynaecological services prominent. While the General Hospital had a focus on general and surgical provision, they offered specialisms such as radiotherapy not available at the BRI.122 A demonstration of this regional capital status had already been seen in the First World War, when the BRI’s new King Edward VII Memorial Wing had served as the poorly reimbursed headquarters for the Southern General No. 2 under the direction of the War Office.123
Specialist hospitals

Bristol’s role as a regional specialist hub was not restricted to services in the general hospitals. An ‘Institution for the cure of Diseases of the Eye among the Poor’ was established in Bristol in 1810, only five years after the first at the London Moorfields. This was an early example of a major nineteenth-century wave of hospitals founded not by charitable benefactors but by medical men.\textsuperscript{124} Although the medical man in question, Surgeon Oculist William Henry Goldwyer, was aided by the patronage of the Duke of Gloucester and the involvement of the Freemasons.\textsuperscript{125} In 1939 the Eye Hospital’s eighty-four beds were being utilised primarily by patients from the city, but one in ten were from Gloucestershire and one in five from Somerset with most of the others from South Wales.\textsuperscript{126}

Another specialist institution founded later in the nineteenth century was the Home for Crippled Children. From 1875 this served as a hospital for children (boys from six months until aged seven, girls ten), employing ‘sun treatments’ to treat infantile paralysis, talipes and spinal curvature or disease, and sometimes from rickets. These patients were usually sponsored by their local municipal health committee.\textsuperscript{127} The Bristol hospital was closed in 1930, with most of the institution’s management committee and patients moved seven miles south to Winford in Somerset.\textsuperscript{128} Most of the patients at the Winford Orthopaedic Hospital (also known as the ‘Bristol Crippled Children’s Open Air Hospital’) suffered from rheumatic heart disease, many of whom were council-funded non-pulmonary tubercular patients.\textsuperscript{129}

Also founded in the late nineteenth century was the Children’s Hospital, beginning in 1857 as a dispensary and settling in 1885 at the site it would occupy for over a century.\textsuperscript{130} The ‘objects of the institution’, unchanged for most of that time, were threefold:

1. – To provide for the reception, maintenance, and medical and surgical treatment of Children under thirteen years of age, in a suitable building, cheerfully and salubriously placed; to furnish with advice and medicine those who cannot or need not be admitted into the Hospital; and also to receive Women suffering from disease peculiar to their sex.

2. – To promote the advancement of medical science with reference to the diseases of Women and Children, and to provide for the instruction of Students in these essential departments of medical knowledge.
3. – To diffuse among all classes of the community, and particularly among the poor, a better acquaintance with the management of Infants and Children during health and sickness; and to assist in the education and training of Women in the special duties of Children’s Nurses.¹³¹

Nearly half of its 109 beds were for general medical cases, while it also provided a range of specialisms, including ENT and gynaecology.¹³² Meanwhile, services for children over women were kept as the sole work of the hospital when war damage reduced it to only fifty-eight beds for inpatients.¹³³

One notable figure in the history of the Children’s Hospital was Eliza Walker Dunbar, appointed house surgeon in 1873 as the first female doctor in any of the city’s hospitals. However, the response to the controversial appointment of a woman was a walk-out by the existing honorary staff. Despite the support of the governors, she soon resigned her post.¹³⁴ During this time she engaged with the city’s notable network of women campaigners and philanthropists, including Miss Read. Bringing together the money of one and the professional training of the other, the Read Dispensary for Women and Children opened in 1874.¹³⁵ It relocated and reopened in 1896 as a hospital, and again in 1931 to sit alongside the city’s elite private practices in the suburb of Clifton.¹³⁶ Following demand, the hospital shifted the focus of its thirty-two beds from general women’s services to maternity during the 1930s. The institution’s story is one of mission drift, from dispensary for the city’s working classes to elite hospital primarily for paying patients.¹³⁷

This was one of a number of maternity hospitals in the city. The Bristol Lying-In Institution, founded in 1865, had its origins in the earlier ‘Bristol Pentientiary’, designed to rehabilitate fallen women.¹³⁸ The new institution was still overtly moralistic, as emphasised in a letter published in the local Western Daily Press in 1886 encouraging donations:

Its object is the immediate shelter of young girls who have gone astray, and as such it is indispensable to the success of other branches of rescue work. Many who have been restored to a life of respectability and happiness acknowledge their indebtedness to the Christian influence exercised over them by ladies interested in the institution, and especially the excellent matron, who seldom fails to win the love and gratitude of those who have been for any length of time under her care.¹³⁹
The early twentieth century, however, saw this change. After the First World War, as at the Salvation Army’s Mount Hope maternity home, married women became the focus, while smaller institutions took over working with unmarried mothers. Meanwhile growing demand for hospital births put pressure on the small Brunswick Maternity Hospital, which entered into a new arrangement with the local health committee in the 1920s. Using its new powers under the Maternity and Child Welfare Act of 1918 and backed by the Ministry of Health, they bought the property and rented it back to the hospital governors. However, by the early 1930s, they decided to close the old Brunswick hospital, as maternity patients were increasingly being admitted to newer facilities. Many of these were new wards at the BRI, which could claim that one-fifth of all Bristol births took place in their wards. The response of the Maternity Hospital was to complain of their ‘reduced numbers’ as a consequence and, in 1932, to poach the BRI’s Matron. It was a rivalry that did not stand in the way of the fifty-bed Maternity Hospital amalgamating with the Bristol Royal Hospital in 1946.

The picture across the city’s maternity and other voluntary hospitals was one of financial difficulties and closures amidst an expansion of services. For instance, at the Children’s Hospital, even as subscriptions declined, other forms of charitable income increased from around one-third of all ordinary income to nearly half over the interwar years. The Wills family spent £13,000 on a new Homeopathic Hospital which opened in 1925, marking the death of Captain Bruce Melville Wills in France in 1915. Developing the work of a nineteenth-century dispensary, it complemented the continuing operation of three dispensaries – two in the working-class areas of St Paul’s and Bedminster, with another in nearby Weston-Super-Mare. The significance of the Homeopathic Hospital is less the service its seventy-nine beds provided and more the demonstration that wealthy benefactors were still capable of founding voluntary hospitals in the city, even in the financially challenging days of the early 1920s.

Another similar demonstration was offered by the establishment of the Cossham Memorial Hospital in 1907. This was ‘a general hospital for the treatment and relief of sick and injured persons of both sexes’ established from the legacy of the Colliery owner, Liberal MP for Bristol East and two-time Mayor of Bath, Handel Cossham. He had declared it his ‘earnest wish that I may be hereafter remembered by the
sick and suffering as a friend who in death as in life has felt it his duty to try and lessen human suffering and increase human happiness'.

With its 100 beds catering for local patients to the east of the city, it was described in the 1930s as being ‘the largest casualty outpost in the City of Bristol’. The hospital’s ‘Subscribers’ were said to be ‘lamentably small’, ‘only about one-fourth of what it should be’. Meanwhile it established an early workers’ governors committee: ‘Without the help of these friends, the 1936 report said, ‘the doors of many hospitals would have been closed or thrown back on the state.’ It serves, therefore, as just one of the examples of voluntary sector expansion in the early twentieth century, alongside the city’s public hospitals.

Public hospitals

Poor law infirmaries

Poor Law infirmaries have sometimes been seen as the nucleus of a public hospital service. In Bristol this meant the sick wards of the workhouses (rebranded as public assistance institutions following the 1929 Local Government Act) at Stapleton and Eastville. A Ministry of Health survey in the early 1930s judged that Stapleton was essentially a public asylum, with fewer than one in five of its 796 patients not certified. Meanwhile, a great many of its patients were ‘aged and infirm persons, who are mostly bedridden’. Those in the ‘sick’ wards at Eastville were primarily treated for diseases of the skin and the respiratory and circulatory systems, for influenza and for senile decay. As at Stapleton, however, over four-fifths of inmates were not medical cases. With an average age of sixty-eight for men and seventy-nine for women, half the bedridden inmates were suffering from chronic diseases, such as rheumatoid arthritis; the other half were ‘bedridden purely on account of age’ in 1930. The Public Assistance Committee’s response was the new Snowdon Road Hospital, which had expanded by 1943 to 478 patients, roughly one-fifth of whom were tubercular patients and most of the rest chronic sick cases.

By the 1930s the largest hospital in the city was Southmead, one of the first poor law institutions to be purpose-built as a medical facility, completed just in time to be brought into the war effort until 1920. A decade later, on 1 April 1930, Southmead was appropriated under the
1929 Local Government Act. As such, instead of passing from the poor law guardians to the Public Assistance Committee, as was the case with Stapleton and Eastville, it was transferred to the Health Committee ‘to ensure that those persons who will receive from the Council by reason of their poor circumstances assistance in the form of hospital treatment shall do so in the same hospitals and under the same conditions as the rest of the citizens.’ Once again, Bristol had pre-empted this progressive change locally. Rather than catering only for paupers, the city’s Medical Officer of Health told the voluntary hospitals that ‘Some time ago the Board of Guardians opened the doors of Southmead for the treatment of sick persons of all classes’. Before appropriation ‘roughly one half were not pauper patients’, and the development of a general hospital for the whole community could therefore take place ‘without dislocation’. The change was not designed to alter the hospital services on offer in the city, but rather to ‘remove the stigma of pauperism.’ This goal was aided by a new maternity specialism, developed in partnership with the university, and increasing maternity admissions were heralded as a sign of success. By 1943, the local press was reporting 2,600 yearly births at Southmead.

**Infectious disease sanatoria**

Besides poor law infirmaries, public hospitals in the city were focused on infectious diseases. Following temporary arrangements, such as the use of the Port Sanitary Committee’s ‘Hospital Ship’, persistent outbreaks of diphtheria prompted the establishment of two institutions. One thirty-five bed isolation hospital was set up in the south of the city at Novers Hill, primarily treating smallpox and occasionally scarlet fever patients. This was followed in 1899 by a much larger infectious disease hospital at Ham Green, on a site of ninety-nine acres with including a mansion and two farms, five miles from Bristol. The initial focus at Ham Green was on diphtheria and smallpox, although temporary accommodation for tubercular cases gradually became more central. By the 1930s it was a major centre for the treatment of infectious diseases, conducting medical research and developing new treatments for pulmonary tuberculosis, bronchitis and artificial pneumothorax. While the medical work of Ham Green expanded, Novers Hill was transferred to the Education Committee in 1934 to become an open air school. This was accompanied by a new 100-bed
sanatorium and open air school for thirty children in a converted eighteenth-century Mansion House at Frenchay Park, to the north east of the city. When 133 were hospitalised in a 1941 outbreak of measles, they were sent to another new public institution, Charterhouse Hospital, sixteen miles to the south of Bristol on the Mendip Hills.

This period of expansion, with numerous new institutions established, had its limits. Bristol’s spending on infectious disease in fact declined during the interwar years. Southmead was appropriated and its clinical standards raised, yet its range of services remained far more focused on chronic and tubercular patients than the voluntary hospitals it sought to imitate. Meanwhile, other public assistance institutions were little changed since their days as workhouse infirmaries. The voluntary hospitals therefore remained the core of acute and specialist hospital provision in Bristol.

**Conclusion**

In Bristol’s hospitals we therefore see reflected a number of defining characteristics of the city. The trading wealth and business connection that had founded the hospitals continued to provide leadership and financial support for expansion in the early twentieth century. This ensured both that Bristol served as the regional medical capital (discussed further in chapter 4) and that there were new institutions and services that needed financing, with one means of doing so being the introduction of patient payments. The city’s early provincial appointment of almoners to set up payment schemes is in line with its eager adoption of some new health and welfare policies, even pre-empting empowerment from central government in some cases, while the slow establishment of the hospital contributory scheme movement (to which we will return in the next chapter) was more in keeping with the much-criticised reticence over collectivist approaches in other cases of welfare and public service provision. The pattern of expansion in health and welfare during the early twentieth century demonstrated that dual expansion was seen in public and voluntary sectors, rather than one crowding out or replacing the other. This trend of the two developing in concert, on increasingly common ground, is something seen in relation to the design and implementation of patient payment schemes. In many respects, therefore, we see the introduction of patient payment
reflecting the defining characteristic of the city’s mixed economies of health and welfare.

The economic, political and social life of the city during the early twentieth century does not only give us the framework for the arrival of payment in the hospitals, but also some insight into context within which it was experienced and understood at the time. Bristol was a wealthy city, but it was also one with significant social problems. These were exacerbated by the unemployment and economic turbulence that followed the First World War, which saw disputes, strikes and riots commonplace in what was, like many others, a febrile city. The rise of Labour as an electoral outlet for dissatisfaction rechannelled some of the tension in the city over the interwar years, but at the time when patient payments were being introduced there were protests over unemployment and retrenchment. While there is little evidence of resentment at being asked to contribute financially to the hospitals, as there was over changes to the benefits granted to ex-servicemen, it would be wrong to entirely separate the new financial dimension to hospital treatment from this wider context. Resented or not, the introduction of patient payments and the later admission of private patients to the voluntary hospitals did raise questions over their charitable nature. Philanthropy was not displaced, although it did undergo something of an identity crisis.

Notes

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22 *Condition of the Poor*, pp. 24–5.
23 The National Archives [hereafter TNA], MH 66/1068, ‘County Borough of Bristol’ Allan C Parsons (Ministry of Health, 1932), p. 27.
29 ‘Lesser Columbus’ (pseudonym) in *Greater Bristol* (London: Pelham, 1893), p. 32.
30 DiGaetano, ‘Urban Governance’, p. 266.
36 Kelly and Richardson, ‘Bristol Labour Movement’, p. 211.
38 Atkinson, Trade Unions, pp. 5–7.
41 Large and Whitfield, Bristol Trades Council, p. 22.
42 Ibid., pp. 22–3.
43 Kelly and Richardson, ‘Bristol Labour Movement’, p. 220.
44 Archer et al., ‘Unemployment Statistics’, ch. 4.
48 Large and Whitfield, Bristol Trades Council, pp. 17–9 and 23–4.
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55 Tanner, Political Change, p. 299.
56 Ibid., p. 287.
57 Archer et al., ‘Political Representations’, ch. 2.
60 Martin, ‘Managing the Poor’, p. 159.
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