State policies and public facility location: the hospital services of north east England, 1948 - 1982

Mohan, John

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STATE POLICIES AND PUBLIC FACILITY LOCATION:

THE HOSPITAL SERVICES

OF

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John Mohan.

Thesis submitted for the degree
of Doctor of Philosophy of the
University of Durham, March 1983.
Abstract


Despite the importance of public facilities in everyday life, as yet there is little agreement on how a theory of public facility location is to be produced. Following a review and evaluation of previous research, it is argued that public facility location should be analysed within the context of a theory of society and of the state. This in turn necessitates an assessment of alternative theoretical propositions concerning the state.

Following this, an account is presented of major developments in the hospital services in the area covered by the Newcastle RHB (Northern RHA from 1974). This account discusses the nature of and reasons for the changing character of state intervention in the British economy since the war, and traces the implications of these changes for spatial aspects of hospital provision. Detailed studies are presented of disputes on local hospital strategy. This material is structured thematically so as to facilitate commenting on the role of the state.

A concluding chapter summarises the empirical material, assesses the relative merits of various approaches to theorising the state, and considers the implications of this research for public facility location theory.

John Mohan
March 1983.
DECLARATION

I declare that the contents of this thesis have not previously been submitted at this or any other university.

John Mohan
March 1983.
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Psychiatric hospitals to which patients from Washington were admitted, 1978
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Research of this nature depends, to a large extent, on access to unpublished documents. The empirical sections of this thesis drew extensively on unpublished material made available by the Northern RHA. I am grateful to Mr. A. Garland of the RHA for granting access to this material and to the staff of the RHA's Planning Division for their hospitality. Malcolm Sellars (Librarian, Northern RHA) and the staff of the RHA's General Office were of considerable assistance in tracing relevant papers, and the Newcastle RHB's accounts were kindly
made available by the RHA's Treasurer's Division.

As well as the papers of the RHA and the RHB, access was granted to the files of Newcastle AHA(T) for a more detailed study. I should like to acknowledge the assistance of Messrs. B. Petfield and A. Black in this connection. Drs. A. Sutherland and M. O'Brien made available papers relevant to the study of hospital planning in the Durham AHA and they also discussed this issue with the author. Papers relevant to the activities of the Board of Governors of the Newcastle Teaching Hospitals were examined thanks to the cooperation of the staff of the General Office at the RVI in Newcastle. Other sources of information included: the Public Records Office; the DHSS libraries at Elephant and Castle and Euston Tower; the King's Fund Centre Library, Camden Town; Tyne and Wear Archives Department; the County Record Offices in Durham and Northumberland; the Local History collections of the municipal libraries of Newcastle, Sunderland and Durham; the Sunderland, Durham and Newcastle Community Health Councils; and the libraries of Durham and Newcastle Universities, and of the London School of Economics and Birkbeck College.

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John Mohan
March 1983.
Glossary of Abbreviations

AHA  Area Health Authority.
AHA(T) Area Health Authority including a Teaching Hospital.
BG  Board of Governors of the United Newcastle upon Tyne teaching hospitals.
CB  County Borough.
CC  County Council.
CHC  Community Health Council.
DGH  District General Hospital.
DHA  District Health Authority.
DHSS  Department of Health and Social Security.
EMS  Emergency Medical Service.
GNP  Gross National Product.
GP  General Practitioner.
HMC  Hospital Management Committee.
IMF  International Monetary Fund.
NCB  National Coal Board.
NGH  Newcastle General Hospital.
NHS  National Health Service.
NTDC  New Town Development Corporation.
PESC  Public Expenditure Survey Committee.
PRO  Public Records Office.
PSBR  Public Sector Borrowing Requirement.
RDC  Rural District Council.
RHA  Regional Health Authority.
RHB  Regional Hospital Board.
RVI  Royal Victoria Infirmary, Newcastle.
UDC  Urban District Council.
A note on referencing

This thesis draws on a variety of documentary sources and this note explains the referencing systems used, as follows:

(1) Published articles and books, and conference papers: the Harvard referencing system is used and the references are listed alphabetically in the bibliography.

(2) Public Records Office (PRO) material: this is referenced according to (i) the department to which it refers, (ii) the file number, (iii) the piece of material from that file. Thus PRO MH 77.25 refers to piece 25 of Ministry of Health File no. 77. References to Cabinet minutes take the form:

CAB Series no.,/volume no., meeting no. (Year) minute. Thus CAB 129/3, 19(50)1 refers to minute 1 of the 19th Cabinet meeting of 1950, held in volume 3 of CAB 129. Quotations from Hansard are referenced by volume, column, and date.

(3) Ministry of Health circulars: these take the form:

Authority to which issued (Year) number, title Thus RHB(50) 41 refers to the 41st circular issued to RHBs in 1950. From 1956 the practice of issuing separate circulars to different bodies was dropped and the designation HM replaced the previous system.

(4) Papers of the Newcastle RHB and of other authorities: these are, in general, referenced by giving the name of the authority concerned, the title of the document, its date, and the file in which it is held. References to minutes of meetings are simply indicated by the name of the authority, the committee concerned, and the date of the meeting.
1. Introduction

This chapter will outline the aims of this thesis (section 1.1), provide a sketch of its structure (section 1.2), and consider the methods employed, the sources of evidence consulted and the problems encountered in the conduct of this research (section 1.3).

1.1 Aims of the thesis

On an autobiographical note, the author's interest in the location of medical facilities dates initially from a period of employment spent investigating alternative spatial arrangements of hospital facilities for Durham AHA. This raised a variety of issues, not only about hospital planning, but also about the adequacy of geographical research on public sector location issues, which seemed to offer some scope for future research.

Consequently, an attempt is made (chapter 2) to provide a selective review of geographical research on public facility location. This will evaluate previous work and put forward alternative proposals, in the light of various arguments which have demonstrated the limitations of the techniques of regional science and - by implication - spatial analysis within geography (Gregory, 1978; Lewis and Melville, 1978; Sayer, 1976). In proposing an alternative, the views of Dear (1978a, 1979) on a reconstruction of facility location theory are evaluated. Specifically, Dear argues that a theory of the state, embedded within a theory of society, is essential to an understanding of the spatial aspects of public facility provision.

With this in mind, chapter 3 reviews and evaluates
alternative theoretical propositions on the state. Pluralist and managerialist views are rejected as being inadequate - on their own - to give a satisfactory account of state policy formulation, the former because of its denial of any links between political power and social class, the latter on the grounds that it overemphasises the role of 'managers' at the expense of an adequate theorisation of the constraints under which they operate. In considering marxist perspectives, particular attention is paid to the work of Offe on the problem of policy formation, since this is crucial to an understanding of resource allocation on the part of the capitalist state.

Following this, the empirical material focuses upon issues in hospital planning in North-East England from 1948-1982, at two interrelated levels. Firstly (chapters 4-7) the development of policies at national level, and their implications for planning at the sub-regional scale, is examined historically, focusing on the problems of hospital planning within the area served by the Newcastle RHB and its successor authority, the Northern RHA (see Appendix 1 for details of NHS administrative structures). The material has been selected in order to explore the validity of the theoretical propositions concerning the state advanced in chapter 3; no attempt has been made to provide a fully comprehensive account of spatial changes in hospital provision within the area studied. Rather the emphasis is on the constraints under which planners operate, upon the way state policies are formulated, and upon their selective character. These issues are explored further by reference to detailed studies of local policy conflicts over the siting of individual hospitals or
groups of hospitals; these studies are of developments in Newcastle upon Tyne, the Sunderland area, and eastern County Durham (chapters 8-10). The material for presentation in those chapters is outlined below; it is believed that it will contribute to the understanding of a variety of issues, as follows.

Firstly, while historical studies exist of the development of the British hospital system (Abel-Smith, 1964) and of the 1962 Hospital Plan (Allen, 1979) there exists as yet no detailed examination of the post-World War II hospital services. Furthermore, while health service policy formulation has received a great deal of attention at the national scale (for example Navarro, 1978; Doyal, 1979; Widgery, 1979; Eckstein, 1959) as yet there is a dearth of studies of planning at the regional and subregional scale. An exception (Ham, 1981) deals with the hospital service only in passing. With specific reference to spatial aspects of hospital planning, Cowan (1967) is an interesting descriptive account, but Mayhew (1979) simply attempts to extend central place theory to provide a location theory for hospital services; neither pay explicit attention to the role of the state in shaping these patterns. In the light of the above, this thesis aims to facilitate an understanding of the changing pattern of hospital provision at the subregional and local scale, focusing on the procedures whereby resource allocation decisions are taken, and interpreting this in the context of theories of the state.

A further theme, to which relatively little attention appears to have been paid, is that of the relationship between the intentions of NHS planners and the objectives of other agencies of the state. With the exceptions of Parston's (1980)
study of the development of health services for the new town of Milton Keynes, and Eyles, Smith and Woods' (1982) demonstration of the contradictory effects of NHS resource allocation and inner city policy initiatives, few studies exist of such issues. Hence an attempt is made to consider the links between hospital planning and other spatial policies in the study area (chapter 8), thereby building on previous investigations of state policies in North East England (Carney and Hudson, 1974; 1976; 1978; Hudson, 1976; 1979; Robinson, 1978).

Thirdly, it is hoped to contribute to the development of a geography of human welfare (Smith, 1977; 1979) by examining in depth the processes whereby patterns of public service provision develop. Spatial aspects of health care provision have been studied at the aggregate, regional scale (e.g. Rathwell, 1980; Eyles, Smith and Woods, 1982), but little has been done on the more local scale, decision-making often being inferred from its outcomes (Phillips, 1981, 169). This research may assist in closing this gap by investigating decision-making in detail.

In summary, the aims of this thesis are fourfold:

(1) to evaluate critically geographical work on public facility location problems, indicating in what direction this could profitably move (chapter 2);

(2) to review and evaluate certain theoretical propositions concerning the state, with regard to their utility in assisting an interpretation of the spatial outcomes of social processes (chapter 3);

(3) to discuss major developments in the acute hospital services of post-war Britain, focusing in particular on the implications of these for hospital planning in the
Newcastle RHB (Northern RHA from 1974 - see Appendix 1) (chapters 4-7);

(4) to reconstruct in detail the decision-making processes whereby hospitals are located (chapters 8-10).

With these aims in mind an outline of the thesis is now presented.

1.2 Thesis outline

Brief accounts of chapters 2 and 3, and of the issues discussed therein, have already been provided; here, attention is directed to an outline of the chapters concerned with issues in the subregional allocation of hospital services (section 1.2.1), and to a discussion of the way the material from the local case studies has been structured.

1.2.1 Hospital planning 1948-1982: national policy and local impacts

Since this thesis is concerned with the post-war hospital services of North East England, it is important to provide an historical background to the problems facing the NHS in 1948. Hence chapter 4 examines the development of the British hospital services prior to the setting up of the NHS, focusing upon the wartime negotiations on the future form of the service and upon the problems which faced planners in 1948.

Chapter 5 then discusses hospital planning from 1948 to 1962, the year in which the Hospital Plan was announced. Firstly, the reasons for the restraint of NHS expenditure in the first few years of the service are examined, and the implications of this for hospital development in the study area are then considered. The origin of the 1962 Hospital Plan is then accounted for in terms of two related developments. Politically,
there was a trend towards economic planning on the part of the British state, while, on a technical level, there emerged proposals for increasing the size of individual hospital units.

Chapter 6 addresses itself to the Hospital Plan and its implementation up to the 1974 reorganisation of the NHS, outlining the proposals of the plan and the impact of revisions to it, considering the constraints on its implementation, and examining the social implications of concentration of hospital services.

Chapter 7 then analyses the implications for hospital planning of public expenditure restraint and/or rationalisation from 1974 to 1982. Two issues are discussed in depth, namely, hospital developments in Newcastle upon Tyne, and the revision of hospital policy in 1980.

1.2.2 The local case studies

These occupy chapters 8 to 10; here, the reasons for their choice are outlined, and a justification is provided for the way the material is structured.

The three case studies are concerned with developments in the hospital services of Newcastle upon Tyne, the Sunderland area, and the eastern part of County Durham. The first of these, the planning of Newcastle's hospital services, was extensively debated by a variety of interest groups and agencies of the state, both medical and non-medical. Hence the interaction of these groups, and the way their competing claims were resolved, is of particular interest; the sheer complexity of the issues involved is in itself sufficient justification for this case study.

The other two examples chosen posed rather different
problems to those of Newcastle, because of the developments in the Sunderland AHA and eastern County Durham - of the new towns of Washington and Peterlee respectively. These developments posed both political and technical problems for health service planners and it is the way such problems were resolved that is of interest.

Rather than simply reconstruct the planning process in each case, however, it was felt that the material would be more profitably employed if structured thematically. This would not only assist in emphasising the themes common to the three issues, it would also facilitate commenting on the role of the state. The material from these three studies was therefore organised as follows.

Firstly, it is argued that it is unrealistic to discuss hospital planning in the study area without reference to more general themes in intra-regional spatial policy in the post-war years. Hence a summary is presented of these themes (chapter 8.1) and their relationship to hospital planning is examined (chapter 8.2). Thus the Washington and Peterlee cases provide useful illustrations of the problems posed for NHS planners by the development of new towns. An attempt is also made to link the theme of the urban redevelopment of Newcastle to the intentions of certain participants in a dispute on the future organisation of the city's hospital services.

Chapter 9 then illustrates the way technical planning procedures have been applied in an attempt to resolve the disputes described in chapter 8; here, the focus is not only upon the technical adequacy of the methods employed but also on the use to which they are put, as well as the extent to which political problems may be solved by such methods. The Durham and Sunderland cases perhaps exemplify this best, but it is also
argued that - in the Newcastle case - a model or image of what was presented as an appropriate form of hospital provision, was used to justify the proposals of one of the groups involved in the dispute over the planning of Newcastle's hospital services.

Finally, chapter 10 considers how the state responds to particular political demands for hospital provision (chapter 10). In Newcastle, this involved a variety of interest groups, prominent medical professionals, planning agencies and local politicians; the interaction of these is of considerable interest. The Durham study illustrates the resolution of a dispute between the Northern RHA and the Durham AHA concerning the criteria on which hospital policy was to be based. Finally, the study of developments in Sunderland AHA exemplifies the way the state responds to community pressure for hospital provision. It is felt, therefore, that organising the evidence in this way permits more general comment to be made on both health service planning and on the operations of the state.

1.3 Methods, sources and problems

The methods employed in this study essentially involve a reconstruction of developments and decisions in the hospital services of North East England. To do this, a considerable variety of state papers, planning documents, health authority material, press, biographical and autobiographical material was consulted, and the intention here is to note some problems associated with these; the principal sources consulted are recorded in Appendix 2.

Investigation of the policies of central government relied on papers held at the Public Record Office (PRO); Ministry of Health and DHSS reports, papers and circulars; and the evidence
provided by Parliamentary committees investigating the implementation of specific policies.

The '30-year' rule - whereby material held by the PRO is unavailable for public inspection for a minimum of 30 years - is, of course, the most binding constraint on an investigation of the internal operations of central government. However, there are also problems with the PRO filing system - such as duplication, preservation of 'unimportant' records and loss of significant ones; furthermore, papers were not always filed chronologically (Pater, 1981, xii). Hence any research based on PRO services is only as good as the filing system in operation there; but, by contrast with the available material for subsequent years, PRO material is extremely valuable insofar as it allows a detailed investigation of the various policy options that were discussed at the setting up of the NHS.

Government documents for the intervening 30 years can be very superficial by comparison; it is not possible to account for allocations of NHS capital expenditure simply by reference to the limited information contained - for instance - in Ministry of Health papers and circulars. This poses especially acute problems when interpreting such a crucial document as the Hospital Plan (Ministry of Health, 1962); it is impossible to reconstruct why some hospitals were to be closed and others developed, other than by inference from the details given in the final policy document (this is not, incidentally, a problem unique to hospitals, as Krieger's (1979) work on coalmine closures shows). Reports of government committees (e.g. Select Committees on Estimates; House of Commons Social Services Committee) may provide more information, though the evidence available is constrained by the membership of the committee
concerned, since the specific investigations pursued are chosen by the members themselves (Ingle and Tether, 1981). On the positive side, the sustained questioning characteristic of such investigations may yield more explicit statements on government policy than are usually available.

For material concerned with more local issues of hospital strategy, reliance was placed largely on the papers of the Newcastle RHB and the Northern RHA; access was also granted to the files of Newcastle AHA (T) for a more detailed study. The material consulted included planning files on major policy issues, correspondence with other statutory authorities (such as NTDCs) and annual accounts and reports, as well as (since 1974) strategic and operational plans, and background papers. The full Board Minutes of the RHB and RHA were not examined; access was available to the papers of the relevant sub-committees of these bodies (for example, the Planning Committee of the RHB) and since this provided detailed information about the policy issues being analysed in depth, there was generally no need to check the Board minutes for further details. Survival of evidence was of course a crucial problem; for instance, the capital accounts of the Board of Governors of the United Newcastle upon Tyne teaching hospitals were unavailable, as well as a variety of RHB files on what appeared to be relevant topics. In addition, the RHB's submission to the Hospital Plan could not be traced.

Additional information was obtained through press, autobiographical, biographical and commentary sources, though such material has only been drawn upon when corroboration from documentary sources has proved impossible. Press sources are problematic to the extent that news is created, rather than
recorded with total objectivity, and for this reason press quotes attributed to prominent public figures cannot necessarily be taken as a totally accurate record of their opinions and intentions. However, since some of the key personnel to which reference is made are now dead, press sources do provide an - admittedly imperfect - source of evidence. Autobiographical, biographical and commentary material may also provide important insights; this is especially so in the case of the diaries of Richard Crossman (1976) and Barbara Castle (1980), which are very useful on the internal workings of central government for a period still covered by the 30-year rule. Crossman (1976 vol. III, 656-659) also provides a detailed account of his personal involvement in the resolution of the dispute over hospital strategy for Newcastle upon Tyne (see chapter 10). Caution in interpretation must be exercised, however, for Crossman almost certainly exaggerates his own role and position; this seems to be the case in the issue referred to. Likewise, writing a biography offers the author a chance to portray his subject in a favourable light, with the benefit of hindsight. Thus Foot (1973) almost certainly over emphasises the role of Aneurin Bevan in setting up the NHS. While Bevan's personal initiative, negotiating skill and political commitment were undoubtedly of importance, a variety of other forces and individuals were involved and Foot's account seems to underplay these - though he does throw valuable new light on the evidence of public documents. Finally, the value of commentary material is, to say the least, uneven, which is perhaps not surprising given the variety of political perspectives from which the NHS has been analysed. While such sources may provide additional evidence to support or illuminate points made in this thesis, the reliance
placed upon them is minimal.

From the above, it should be clear that the various sources of evidence employed present a variety of problems. Though these might be overcome - at least in part - by interviews with key decision-makers, reliance on this source poses two further problems. One of these - the problem of identification of key personnel (Saunders, 1979, 328-335) - is not crucial here; in the issues discussed it was usually possible to identify influential individuals from the papers to which the author had access. However, the modus operandi of state agencies in contemporary Britain is such that the formal meetings of - for instance - an Area Health Authority - may be of limited value to an understanding of decision-making. This is because the influence of administrators is crucial in terms of selecting and evaluating alternative policy options, and so the examination of background papers, and of documents concerning meetings of Authority members and officials, prepared by health authorities, is perhaps the most vital source of evidence drawn on here. This is not meant to imply that power is concentrated in administrators as a result solely of their technical expertise. Rather it is to suggest that detailed analysis of the record of events outside the formal meetings of NHS planning bodies is of some importance if a full account is to be given of the manner in which policy options are debated. In this sense there would be relatively little to be gained from interviews moreover, the value of interviews is limited by problems of recall and possibly, indeed, by the selective character of individuals' accounts of events (Ham, 1981, 14). Though formal interviews were therefore avoided, it should be noted that considerable time was spent in health authority offices while
gathering information. This gave the author an opportunity both to observe the on-going work of a planning department, and to discuss NHS planning in some detail with those involved in it.

1.4 Summary

This introductory chapter has provided an account of the aims and structure of the thesis and of the sources of evidence used and of the problems associated with these. Since the basis of the thesis is an essentially interpretative approach - as argued in chapter 2 - it would be premature to state any conclusions at this point. Comments specific to each chapter are included at appropriate points, and the concluding chapter draws together the main themes of the thesis, assesses the extent to which its aims have been fulfilled, considers the problems encountered, and points to areas to which future research might be directed.
2. Human geography and public facility location: a review, evaluation, and some proposals.

2.1 Introduction

Despite the aims of Teitz's (1968) sketch of a public facility location theory, Harvey (1973, 90) was still able to claim that geographical work on this subject had 'not progressed very much beyond the point of relatively simply model articulation'. More recently however, Dear (1974; 1978a; 1979) has outlined alternative proposals for facility location theory. This chapter reviews and evaluates the proposals of both Teitz and Dear, commencing with a discussion of the work of Teitz and the research stimulated by him (section 2.2). This is then evaluated (section 2.3) and section 2.4 then presents an assessment of alternative proposals for public facility location theory, drawing not only on the views of Dear but also on a variety of commentaries on developments in human geography (Gregory, 1978; Harvey, 1973; Lewis and Melville, 1978; Sayer, 1976).

Before proceeding, three points should be made clear. Firstly, the intention is not to provide a comprehensive literature review since detailed bibliographies (Freestone, 1977; Lea, 1973) and reviews (Hodgart, 1978; Lea, 1981) already exist. Rather the literature is used selectively, to exemplify particular problems of certain approaches to this topic. Secondly, considerable emphasis will be laid on the arguments of Teitz and Dear - the only authors who have explicitly attempted to develop a theory of facility location - and this is somewhat problematic; in evaluating the contribution of individuals to a discipline,
selective quotation could create a misleading impression (Lewis and Melville, 1978, 92). Thirdly, some criteria are evidently required against which alternative approaches to the development of theory may be assessed. Though a full review of the varied debates, in both the physical and human sciences, concerning the grounds on which such decisions are made would be beyond the scope of this thesis (see, inter alia, Kuhn, 1970; Lakatos and Musgrave, 1970; Feyerabend, 1975; Giddens, 1976; Johnston, 1979a; Wheeler, 1982) emphasis here is laid on two criteria.

Firstly, an assessment of previous work on public facility location is provided which considers the technical difficulties of modelling facility systems, the problems inherent in attempting to construct a location theory for public facilities along the same lines as that developed for industrial location, and the extent to which previous research has been able to consider all issues relevant to its object of study.

Secondly, while the problems identified could perhaps be resolved, at one level, via more sophisticated techniques, it is also necessary to assess the extent to which the work reviewed gives a satisfactory account of its object of study. For example, it may be that the techniques of spatial science discussed below provide little more than a generalised mathematical representation of the outcomes or appearances of social processes.

In presenting this evaluation the emphasis will largely be on assessing previous work on its own terms. It will be argued that several problems exist which will not be overcome within existing frameworks but which, instead, require an alternative conception of theory. In putting forward such an
alternative the views of Dear (1978a, 1979) are accepted as a point of departure, though several issues require clarification; these concern not only Dear's justification for his views but also certain weaknesses in his arguments. Discussion therefore commences by reviewing Teitz's original proposals and the research which has followed them.

2.2 Public facility location: a review of research in human geography.

Until the mid-1960s, research on public sector location problems had been limited in scope; Thompson (1965, 118) contends that public finance concepts had been 'largely spaceless' and facility location had received scant attention in the literature concerned with service provision (see, for instance, the bibliographies on central place theory by Berry (1967) and Berry and Pred (1961)). Noting the importance of public facilities in everyday life (Teitz, 1968, 35) Teitz attempted to construct an independent location theory for public facilities; the emergence of his proposals can be related to four factors.

An overall context was undoubtedly provided by what Peet (1977, 243) terms society's demands for 'spatial efficiency and strategic planning' - witness, for instance, the establishment of the Centre for Environmental Studies under the Labour Government in Britain (Crossman, 1976 (vol. 1) 233). Secondly, the developing techniques of spatial operations research (Cooper, 1963; Kuhn and Kuenne, 1962) were allied, thirdly, to an (assumed) analogy between private sector location theory and the characteristics of public facility systems. Finally, the extension and refinement of computer technology facilitated the solution of the colossal combinatorial problems involved in the
spatial analysis of facility systems (see Tornquist et al., 1971; Scott, 1970; 1971). It was against this background that Teitz attempted to sketch a theory of public facility location, though he restricted himself from the start by proposing that this could be achieved simply by extending the substantive domain of regional science to include public facilities (Teitz, 1968, 35). Hence Dear's (1978a, 97) observation that Teitz had both 'stimulated and confined' research on facility location; the following amplifies this by summarising Teitz's views.

Though Teitz argued by analogy with private sector location theory, he recognised two qualifications. Firstly, the objective function of a facility location theory would differ from that of industrial location theory; whereas in the latter, concepts of profit and loss could be operationalised with little difficulty, this was not true for the public sector. Secondly, public facility provision has to be evaluated in system terms. In its neoclassical form, by contrast, private sector location theory usually focuses on the locational strategies of individual production units in response to market forces (see Smith, D., 1971, for a review). However, in the public sector, the question of whether or not individual units should continue to operate is not simply subject to market forces. It follows that analyses must consider not simply static location problems for individual units, but rather multiple location problems in a dynamic framework. At best this poses serious analytical problems; at worst, it may well be that the construction of a location theory for public facilities - along the lines of that developed for the private sector - is an impossible task.

Teitz then classified public facilities, in terms of their outputs (public or collective-use goods; zero or short-run
marginal cost goods; and merit goods); their geometric properties (point patterns or networks); their interactions (both with other facilities and with the rest of the urban system); and in terms of the extent to which they exhibited hierarchical structuring.

Thirdly, Teitz noted that, since public facilities were the responsibility of the government, the operational criteria whereby they were allocated could not easily be specified. Being unable to incorporate the political aspects of service provision into his proposals, Teitz conceded that 'most of the interesting problems still remain'; he therefore confined himself to an identification of the 'opposing forces of the economies of scale and the advantages of dispersion' (Teitz, 1968, 42) and indeed a considerable quantity of research has addressed this 'equity versus efficiency' aspect of public facility location (Symons, 1971; McAllister, 1976, McGrew and Monroe, 1975; Bigman and Revelle, 1978; 1979).

Finally, Teitz's models of how public facilities might be provided took as their point of departure a 'formidable' set of assumptions concerning demand, cost and pricing mechanisms, and derived likely relationships between several variables, such as scale and consumption, scale and cost, and scale and number of facilities (figure 2.1 a,b,c). Crucially, however, Teitz admitted that he was 'unable to incorporate the location problem into a pure analytic model' - though he did offer suggestions as to how this might be achieved.

In summary, therefore, Teitz's principal contribution to facility location theory was to identify the potential applicability of the techniques of regional science to this topic. Much subsequent research has remained within this
Figure 2.1a: Scale on consumption

Figure 2.1b: Cost on scale

Figure 2.1c: Cost and number of components

Source: Teitz (1968)
framework: typically, linear programming models, computer

technology and analogies with private sector location have been

used to solve location-allocation problems. These can be

regarded as special cases of mathematical programs; they seek
to optimise flows - of goods or people - between supply and
demand points, in relation to specified objective functions and

subject to specified constraints (Beaumont, 1979; 1980). An

example from private sector location theory would be Weber's

(1909) model of industrial location: taking their cue from this,
initial analyses of facility location had sought that spatial

arrangement of services whereby aggregate distance travelled
was minimised (e.g. Cooper, 1963; 1967; Kuhn and Kuenne, 1962).

More recent developments have sought to relax some of the over­
simplistic behavioural assumptions of earlier models, for instance
by the incorporation of spatial interaction concepts (Beaumont
1980). Such procedures have been increasingly widespread in
their application (e.g. Godlund, 1961; Cox, 1965; Gould and

Beaumont and Sixsmith, 1982) and a considerable range of

techniques are now available (see Leonardi, 1981a, b; Leonardi
and Mayhew, 1982; Mayhew and Leonardi, 1982). Few would
dispute the view of Olsson (1975, 49) that such developments
are admirable, if only for their technical virtuosity, but it
will now be argued that problems related to and inherent in
such work seriously restrict its contribution to the development
of a comprehensive public facility location theory. These

arguments are now outlined.
2.3 Evaluation

Following the arguments of section 2.1, the research discussed above is now evaluated. Section 2.3.1 considers some technical problems pertinent to the modelling of facility systems, and notes some of the issues given limited consideration, or even ignored, by previous work. Section 2.3.2 then contends that even if the problems outlined in section 2.3.1 were soluble by more sophisticated techniques, there are grounds for the claim that the construction of a location theory for public facilities, similar to that developed for the private sector, is an unrealizable goal.

2.3.1 Limitations of previous research on facility location

Two points are made here. The first is that previous research has provided a restricted account of issues related to its object of study. Secondly, the approach taken by various analysts has in itself confined the manner in which this topic can be discussed.

Firstly, it seems that mathematical programming solutions to location-allocation problems dominate the literature, at the expense of a consideration of the distributive consequences of decisions in the public sector. The conventional assumption that the analogy with Weber's industrial location model was both appropriate and socially acceptable (Scott, 1970, 96) has, in fact, produced inequitable solutions; distance-minimizing procedures imply a concentration of facilities into large centres of population, thereby discriminating against some people or areas (Morrill, 1974, 41). One response has
been to analyse the supposed trade-off between 'efficiency' and 'equity' in service provision (e.g. McAllister, 1976; McGrew and Monroe, 1976). Efficiency is usually taken to imply some kind of distance-minimisation criterion, whereas equity is associated with a more dispersed pattern of provision which, though 'suboptimal' if evaluated in aggregate distance terms, reduces the variability in distance travelled by users of facilities. Since public facilities are generally provided at discrete locations, it is evidently impossible to reconcile completely these two objectives, the closest approximation, given an acceptance of his assumptions, being the hypothetical pattern of Christaller's central place theory (Morrill, 1974). An alternative response has therefore been to attempt to incorporate more sophisticated concepts of equity (Kellerman, 1981) and accessibility (Bach, 1980; White, 1979) into modelling procedures. This arguably approximates more closely to real-world conditions, but posing the problem of public facility provision in technical terms, as a trade-off between equity and efficiency, may ignore - whether intentionally or not - both the purposes of and constraints upon state intervention (Scott and Roweis, 1977, 1111; see also Lindberg et al, 1975). Indeed such criteria as efficiency or equity cannot be taken as 'non-scientific presuppositions about which one can do nothing' (Horkheimer, 1972, 207); put another way, there is no justification for ascribing some kind of absolute status to 'equity' or 'efficiency', since they are essentially relative concepts.

It can be argued, therefore, that by attempting to develop more sophisticated modelling procedures, analyses of public
facility location within the framework of regional science have considered only a limited range of issues; though the distributional aspects of public facility provision have been discussed, this has largely been in the context of analysing the 'equity/efficiency trade-off', and still less discussion is evident of the political aspects of this topic. Alternative approaches which attempt to bridge these gaps are themselves not without problems. For instance, analyses of the distributional impacts of public facility location, within the spirit of a 'welfare' geography (Smith, D., 1977; 1979) have encountered technical problems related to the measurement of such issues as accessibility (Moseley, 1979), externalities (Dear, Fincher and Currie, 1977), and need or demand for services (Davies, 1968; Runciman, 1967). Though important evidence on distributional inequalities has been gathered (Coates and Rawstron, 1971; Coates, Johnston and Knox, 1977; Cox, 1973; 1980; Smith, D. 1973; 1977; 1979), the accumulation of such evidence may be 'counter-revolutionary' (Harvey, 1973, 144-145) unless it is interpreted within a satisfactory theoretical framework, and it has been claimed that such a framework does not exist as yet (Dear, 1978b). However, it will be argued below that this problem may be overcome by an appropriate reorientation of facility location theory.

Furthermore, the political aspects of public facility provision have received limited consideration. This is not surprising in the case of analyses of this subject within the framework of regional science; political issues are treated as beyond the researcher's sphere of competence, given a conception of social science in which the analyst merely provides a
technical input to the solution of social problems. (Lewis and Melville, 1978). More generally, it may be that there exists confusion over what is 'political' about political geography (Taylor, 1982). Whatever the reason, consideration of political aspects of public service provision has been partial and limited. Three approaches can be identified. Firstly, statistical associations have been identified between service distribution and 'political' variables such as voting patterns or the political composition of local authorities (see, for instance, Pinch, 1978; Johnston 1979 b, c). However, such work cannot permit the unambiguous identification of linkages of a causal character. Secondly, procedures have been developed to simulate locational conflict over service provision (Austin et al., 1970; Mumphrey and Seley, 1973); however, such approaches merely attempt to pick out features common to disputes rather than analysing why decisions happen the way they do. Thirdly, the role of 'urban managers' in shaping spatial patterns has received much attention (see, for example, Duncan, 1976; Gray, 1976; Leonard, 1980; 1982; Moon, 1981; Williams, 1976; 1978; 1982). However (as will be argued more extensively in chapter 3) such approaches ultimately over-emphasise the actions of individuals or institutions, at the expense of a fuller consideration of the constraints under which they operate. However, despite extensive debates on the role of the state, almost no attempts have been made to relate them to patterns of public facility provision (but see Eyles, Smith and Woods, 1982; Leonard, 1980). It therefore appears that analyses of political and distributive aspects of public facility provision have not been entirely satisfactory, especially in terms of accounting.
for the spatial outcomes of public decisions.

Furthermore, it may not be possible to develop a location theory for the public sector along the same lines as private sector location theory. Dear (1974, 47) argues that notwithstanding the problems associated with the neo-classical theory of the firm as a basis for location theory (on which see Massey, 1973), the concepts of such theory have simply been transmitted to the public sector in a 'superficial tinkering' with private sector location theory. Moreover, by remaining within the epistemological confines of regional science, research has concentrated largely on more accurate representation in modelling procedures, which have become increasingly sophisticated (see Beaumont, 1979; 1980; Leonardi, 1981 a, b). The internal consistency and technical sophistication of such work is not at issue here. However, by focusing largely upon technical issues, such research may slide into what Carney (1973, 175) terms a 'point pattern positivism', which only contributes to a comprehensive theory of facility location to the extent that it permits more 'rational' or 'realistic' spatial planning. But this begs the question of whether, given the complexity of state policy making, optimisation of public decisions is possible. The number of factors which have to be taken into account by the state in formulating its policies is considerable (Harvey, 1973, 90; Dear, 1979 a, 59). Moreover, structural constraints on the operations of the capitalist state render its goals difficult to specify and limit the extent to which its intentions can be achieved (see chapter 3; see also Habermas, 1976 a, b; Offe, 1974; Offe and Rønne, 1975). Indeed the term 'optimisation' - which is used freely in the analyses reviewed here - is a relative, socially-defined concept, which
means different things to different people in different historical circumstances. Spatial modelling procedure thus seem to be attempting the impossible: how can decisions be 'optimised' if the meaning of optimisation changes, and if it is impossible to identify what goals the state is seeking to achieve?

It should be clear from the above, that there remain several obstacles to the development of a comprehensive theory of public facility location. The fragmented and limited treatment of the subject is one aspect of this; doubt has also been cast on the possibility of paralleling private sector location theory in a public sector context; and certain problems remain in studying distributional and political aspects of facility location. However, these criticisms are at a relatively low level, emphasising gaps in the literature or hinting at technical problems. The next section therefore points to problems inherent in the techniques of regional science which limit its ability to 'explain' the phenomena to which it is applied.

2.3.2 Some theoretical problems of regional science.

Clearly, some important deficiencies exist in geographical research on public facility location. Of more fundamental importance, however, the kind of theory advocated by Teitz - confined within the methodology of positivist regional science - gives only a limited account of the issues it addresses. This is because of its debt to functionalist sociology and neoclassical economics, and because of an adherence to a form of explanation which may ultimately be self-defeating. From these arguments it will be claimed that the problems identified are not soluble within this theoretical framework.
The linkages between human geography and neoclassical economics have been adequately demonstrated elsewhere (Gregory 1978, 1981b; Massey, 1973) and are evident, in this context in the application of concepts from private sector location theory to facility location problems; an obvious example would be the assumed parallel with Weber's (1909) theory of industrial location. Two problems arise. Firstly, such a form of theory exhibits spatial fetishism; by treating space as if it were a given, abstract, and absolute category (Sayer, 1976), it treats relations between people, between people and places, or between individuals and society, in a very limited way (see Carney, Hudson, Ive and Lewis, 1976, 25; Anderson, 1973; 1978).

Thus it fails to provide an adequate account of how spatial patterns of objects - in this case public facilities - are related to social relationships between the people who created them (Lewis, 1978, 513). Secondly, such a theory is static, in that it takes as given the character of the organisation of the society to which it is applied and within which it is produced. Thus analyses of facility location tend to ignore, or treat as unproblematic, the wider social context of their object of study and the fact that this context is continually changing. Moreover, because of their neglect of the relationships between patterns of public facilities and the organisation of the society within which they are provided, simply developing models of change over time will not resolve the problems identified here.

These problems are compounded by the functionalism implicit in regional science. Since the problems of functionalist approaches to social theory in general and regional science in particular have been analysed elsewhere (Giddens, 1979, 1982; Sayer, 1976), discussion focuses on two issues although the two problems referred
to above also arise from such approaches.

Firstly, functionalist approaches are characterised by a concern for observable aspects of human behaviour; they therefore ignore the motivations which underlie behaviour, and the constraints upon it. Hence, modelling spatial aspects of health facility systems ignores the relationships between an individual's health status and his/her decision to seek health care (Cornwell, 1982). Likewise, once this decision has been taken there exist a variety of constraints imposed by the spatial arrangement of medical facilities (Girt, 1973; Hart, 1971; Haynes and Bentham, 1979), by gender (Coupland, 1982) and class (DHSS, 1980b), and by the referral patterns of medical practitioners (Acheson et al, 1962; Hassan, 1974; Rigby, 1978).

Put another way, the limited consideration given to the social relations between individuals and institutions may render trivial the insights of such research - and indeed of much of behavioural geography more generally (see Massey, 1973; Rieser, 1972).

Secondly, an instrumentalist attitude to research characterises functionalist approaches. Although the construction of universalistic laws in the human sciences may be an unrealistic project (Giddens, 1979, 242-245), the development of models which analyse society as if this were the case is justified - it is claimed - because models need only be operationally useful approximations which serve as stimulating analytical tools (see Batty, 1979, for such a defence of regional science). Such a procedure only assesses models in terms of their predictive power and goodness of fit, rather than questioning their mode of construction (Gregory, 1978, 41); the latter may well be self-defeating in terms of the kind of
issues that can be considered. As Sayer (1979a, 859) argues:

'in the very first step of theorising, we throw away the most important opportunities for understanding... talk about residential activities and you can quickly define H and maybe H_2^{KW}, but you have defined out descriptions of the mechanisms and agents which produce housing'.

(emphasis added)

Hence attention is directed to improving the goodness of fit of models, without questioning whether such procedures really assist an understanding of social processes. Moreover, when leading protagonists of such views argue that 'issues of theory... are all concerned with making models more realistic' (Wilson and Clarke, 1981, 11), the implication is clearly that research should seek increasingly accurate representation in modelling procedures, presumably in the belief that (ultimately) all the variables pertinent to the system of interest will be incorporated. This may be over-optimistic, however, because as Gregory (1978) has argued, positivist approaches to social science may ultimately collapse on their own terms. Since they are based upon deductive logic, such methods can only draw out what was implicit in their definition. The logical certainty of the conclusion is guaranteed by using such methods (Harvey, 1969, 37) but this will not necessarily specify the social processes whereby the conclusion actually happens (Sayer, 1979a, 860). Moreover, positivism cannot (ultimately) achieve its aims for two reasons.

Firstly, it relies on constant relationships between observational and theoretical categories, yet this is inadequate insofar as it employs stationary categories of thought to deal
with a shifting universe (Olsson, 1974). Such a problem will not be resolved by attempts to reformulate location theory within the framework of welfare economics (e.g. Chisholm, 1971; Lea, 1979) for this also implies such a constant relationship (Gregory, 1978, 64-65). Secondly, positivism relies on a deductive-nomological form of explanation, of the form:

\[
C + \text{Initial Conditions} \rightarrow L \text{ Laws} \rightarrow \text{Ceteris Paribus Events} \rightarrow E \text{ (after Gregory 1978,66-67)}
\]

Yet this does not permit the definitive acceptance or rejection of hypotheses, since if a predicted event does not occur, it is impossible to distinguish the failure of the hypothesis from the failure of all conditions external to the test of theory to remain constant. Thus, for example, if models of spatial aspects of facility systems fail to 'correspond' to reality, there is no way of divining the reasons for this; it may be due either to incorrect model specification, or to the influence of external factors, but there is no way of separating these.

This section has attempted to reinforce the arguments of section 2.3.1 by highlighting various problems internal to regional science - particularly its functionalism and positivist epistemology - which limit its explanatory power. Responses to such criticisms have attempted to justify the further development of such models on the instrumentalist grounds (e.g. Batty, 1979) that they provide useful planning tools. However, it should be evident that continuing to analyse facility location from such a perspective is somewhat problematic and so an alternative
approach is explored below.

2.3.3 Summary

This section has attempted to show how and why a comprehensive public facility location theory has not yet been developed within human geography; two principal arguments have been presented. Firstly, there has been excessive emphasis upon developing sophisticated mathematical programming techniques for the analysis of facility location. In consequence, several issues - such as the political and distributive aspects of facility location - have received limited consideration. Secondly (section 2.3.2) there are grounds for the claim that the methods employed will not provide an adequate theory due to a variety of theoretical problems internal to regional science. The foregoing has shown that these problems will not be resolved within the frameworks criticised here and therefore section 2.4 explores the potential of Dear's (1978a, 1979) arguments for a revision of public facility location theory.

2.4 An alternative: public facility location theory as a 'theory of society'.

Here the arguments of Dear (1978a; 1979) are outlined and then evaluated. Though Dear's proposals seem to represent an advance on the work reviewed above, several problems remain and require resolution.

Dear's point of departure is that the 'paradigm' proposed by Teitz has 'stimulated and confined' research on public facility location, prevented experiment with alternative analytical formats, and (within this 'paradigm') attempts to incorporate concepts of equity and also political aspects of
facility location, have been conceptually naive (Dear, 1978a, 97). Such claims, which rest on similar arguments to those of section 2.3.1, are taken as non-contentious here.

Dear then follows Gregory (1978) in identifying human geography's excessive commitment to a positivist epistemology, and claims that progress away from this depends on reconstruction of facility location theory as a 'theory of society', by adopting an historical-hermeneutic approach to social theory. This would facilitate interpretation of why patterns of public facility provision had taken the form they did; this would be achieved by setting and interpreting location decisions in the context of the 'wider social formation'. Dear also argues that two other components are an integral part of a reconstituted facility location theory: these involve consideration of location as access and location as externality. Taken together, these would permit an assessment of the direct and indirect impacts of public decisions upon human welfare (Dear, 1978, 99).

Finally, Dear argues that a theory of the state, embedded within a theory of society, is of central importance to his alternative (Dear, 1979, 53-54). While only a sketch of Dear's position has been presented, it can be shown that various problems remain unresolved within it.

Firstly, Dear's case could have been made somewhat more forcefully. For instance, a critique of certain theoretical problems internal to regional science, along the lines of Sayer (1976), would have enabled a more convincing demonstration that such an approach cannot provide a comprehensive public facility location theory. It does not follow from Dear's arguments that the problems he identifies are insoluble within
the terms of reference of regional science. For instance, to argue (as he does) that concepts of equity have been 'conceptually naive' does not rule out the possibility that more sophisticated concepts could - and should - be developed, thereby overcoming this problem. Moreover, a fuller consideration of the nature and properties of the capitalist state would have underlined that applying the techniques of regional science to public facility location problems is ultimately inadequate. This arises from the contradictory tasks the state must carry out, and from the constraints upon and limits to state intervention (see chapter 3). Such arguments would have reinforced Dear's (1979, 61-62) claim that equilibrium approaches to theory - based upon a consensus view of society and exemplified by the work reviewed above - ought to be replaced by views of society based on conflict (cf. Gray, 1975; Eyles, 1974), in order to take account of the various constraints on the planners of public services. In this way, moreover, the apparent optimism of various authors (e.g. Mayhew, 1979; Beaumont, 1980) that spatial reorganisation of hospital services can easily be accomplished - or indeed 'optimized' - can be shown to be at best exaggerated, and at worst, the pursuit of an illusory goal.

Strengthening his critique in this manner would have given Dear firmer grounds for his reformulation; in turn, this would have helped avoid the eclecticism which characterises his proposals. In particular, these appear to place questions of epistemology on the same level as matters of technique. The three components of Dear's proposals are concerned with location as externality (the indirect impacts of service provision), location as access (direct benefits to users of facilities); and location decisions in the context of the wider social formation
(Dear, 1978a, 99). Though the first two of these are doubtless important, Dear focuses largely upon technical aspects of their assessment - for instance, by employing various regression analyses to 'explain' patterns of service utilisation (Dear, 1978a, 101-103). Such questions are at a lower level of abstraction than that of the conceptualisation of the 'wider social formation', insofar as they take that context as given; by contrast, an understanding of location decisions in the wider social formation would essentially be historically specific.

Moreover, despite his advocacy of an historical-hermeneutic approach to theory, in preference to an empirical-analytic approach, Dear retains a place for the latter: 'mathematical and statistical methods have an integral role to play' (Dear, 1979, 62). How - indeed whether - alternative epistemologies can be combined in this way, is a contentious issue; as Eyles and Lee (1982 - in response to Johnston (1980)) argue, it is not legitimate to see them as complementary routes towards an explanatory account of social phenomena. Such eclecticism could slide into a relativism whereby 'conservative methodologies, liberal idealists, marxists, socialists and others can co-exist' (Dear, 1979, 64), linked by a common interest in a particular facet of society but having no grounds for moving from one frame of reference to another. Though this might be acceptable to certain philosophers of science (e.g. Feyerabend, 1975), it does seem (see section 2.3) that grounds exist for advocating alternative approaches to replace - not to complement - those currently dominant in the literature, and these grounds are somewhat firmer than those offered by Dear.

Partly as a result of this eclecticism, then, Dear merely
asserts the superiority of an historical-hermeneutic approach. This would be validated by the success of its interpretations; in contrast, empirical-analytic approaches (typified by much of the work reviewed above - see section 2.2) are validated by successful predictions. Put another way, a distinction must be made between a social science based upon verstehen (or understanding of human behaviour) as opposed to erklären (explanation of behaviour in a manner analogous to the natural sciences - see MacDonald and Pettit, 1981, for further details). Choice of an historical-hermeneutic approach could lead to the kind of idealism espoused by Guelke (1974), which attempts nothing more than a reconstruction of the behaviour of decision-makers. While not disputing that considerable work is essential if decision-making processes are to be reconstructed in detail (see chapters 8-10, below), to equate such accounts with explanation is to remain at a purely voluntaristic level (Harvey, 1969, 56), as long as no account is taken of the constraints under which decision-makers operate. How this is to be accomplished occupies much of the remainder of this chapter: a materialist approach will be advocated, and Dear's views will be assessed in this context.

A materialist approach is advocated for two reasons. Firstly, Marx argued that a comprehensive understanding of society cannot be obtained through direct experience, since there exists a distinction between the appearance of phenomena and their essence. Science is necessary precisely because appearance and essence do not coincide (Mandel, 1975, 15). Secondly, so as to link the two, a materialist approach emphasises that society has to be conceived of as a totality which is subject to continuous,
dialectical transformation.

The importance of such an approach to the subject matter of this thesis is that positivist methods for analysing facility location have merely tapped reality at the level of appearances, focusing on technical aspects of spatial modelling procedures. In addition, the fragmented nature of previous research - focusing on, respectively, the political, distributive, and externality effects of facility location, but rarely linking them - was emphasised above (section 2.3). The advantages of a materialist approach here are in its ability to link essence and appearance and, in so doing, to assist in integrating the diverse research on this topic.

There are, however, a variety of approaches to a materialist view of society. These will not, however, be examined in detail (see Giddens, 1982; Collier, 1978); instead three central features of historical materialism are identified. Firstly, materialism as a conception of human praxis, sees human beings neither as passive subjects nor as totally free agents. Secondly, materialism is a theory of social change which emphasises the primacy of economic factors; as will be shown below, however, this does not have to imply that the 'economic base' determines the 'superstructure' of society. Finally, materialism offers a theory of the centrality of class divisions in society. The value of each of these features will be discussed in turn.

First of all, materialism as a conception of human praxis provides valuable insights into the nature of human agency and its relationship to social structure. This was recognised by Marx in his argument that 'men make their own history but they do so under conditions not of their own choosing' (Marx, quoted
in Collier, 1978, 46). Hence it is inadequate simply to trace decisions to key individuals and, having done so, regard this as a satisfactory explanation. Such accounts only succeed in describing what human agents have achieved; they say little or nothing about the conditions under which certain decisions have been taken (Collier, 1978, 48). As will become evident in the next chapter, focusing upon individuals' perceptions and subsequent behaviour may lead to voluntaristic explanations. However, it is important not to proceed to the other extreme, in which no scope at all is given to the actions of individuals; it is for this reason that some commentators have reacted sharply against what they see as an over-mechanistic view of human agency in certain Marxist approaches (Duncan and Ley, 1982) whereby history is reduced to a 'conceptual meccano set' (Thompson, 1978, 359). The value of a materialist view lies precisely in its 'contradictory combination of determinism and voluntarism' (Gouldner, 1980, 224). Thus the outcomes of state policy formulation are neither solely the result of interactions between individuals, acting in unconstrained pursuit of their own goals, nor are they simply a consequence of the inexorable logic of the 'laws of motion' of capitalism, mediated through agencies of the state. Consequently it is important to understand - in general terms - the limits to the scope of possible policy formation by the state, as well as examining what are essentially contingent outcomes in order to understand why particular decisions take the form they do, and to understand the extent to which the individual decision-makers possess - and are able to exert - autonomy in planning.

Secondly, while historical materialism, as a theory of
social change, lays an emphasis on the primacy of economic factors, this is not to imply that the 'economic base' determines events in the 'superstructure'. Unfortunately, Dear's arguments seem structuralist and rather economicistic:

'the pattern (of public facility provision) is inextricably determined by the contemporary socio-economic and political context... there is a direct correlation between social policy and spatial outcome'.

(Dear, 1978a, 107, 110 - emphases added).

Likewise, Dear argues that a geography of the public sector should focus upon:

'the material (especially economic) basis of society, and particularly the processes whereby it determines the superstructure of social, legal and administrative solutions'.

(Dear, 1979, 63 - emphasis added).

Such a view sees the state as little more than an epiphenomenon - a reflection - of the economic base of society, yet, as various authors have demonstrated (see the debates summarised in chapter 3 and in Frankel, 1979; Gold et al, 1975; Holloway and Picciotto, 1978; Jessop, 1977) this would be a greatly over-simplified and impoverished view of the capitalist state. Thus, despite claiming to have sketched a theory of facility location within an historical-materialist framework (1979, 63), Dear retains more than a hint of arid structuralism in his proposals. This is not merely a semantic quibble, because it is not adequate simply to 'read off' spatial patterns from the 'processes of capitalist economic development', as Gray (1975, 231) seems to imply. Rather, the particular spatial patterns taken by - for example - the hospital services of North East England, are essentially contingent outcomes. These depend - inter alia - on the results of complex negotiations within and between agencies of the state, and between these and
social groups located outside of the formal state apparatus (see chapters 4-10). Though Dear points towards the broader social context within which public facility location must be understood, the above quotes might be taken to imply a theory which simply demonstrates that 'the spatial lattice exhibits, in frozen and displaced form, a bundle of social relations' (Gregory, 1978, 120). If this were indeed the case there would be relatively little point in conducting empirical research on spatial patterns of human activity, for it would be possible to derive these logically from the socio-economic context in which they were set. Such an approach would not only be entirely mechanistic in character but - to return to the previous point - it would rule out any consideration of the role of individual decision makers and their relationship to wider social structures (see Gregory, 1981a). It may be concluded that Dear's 'theory of society' is somewhat mechanistic in conception, and that the relationship between the state and the economy requires rather more detailed investigation - a task carried out below (chapter 3).

The third aspect of an historical materialist approach emphasised here is its stress upon class struggle and class division in society. Instead of analysing society at the level of appearances via such 'chaotic conceptions' as total population (for example), and moving from these towards an understanding of society at a more abstract level, Marx (1973,101) emphasises the central importance to be attached to property relations and social class in analysing society. Whereas the approaches reviewed above (section 2.2) have provided little more than generalisations about public facility systems at the level of appearances, this thesis seeks to illuminate the class
character of the state, its implications for policy formulation, and thus demonstrate how the outcomes of state administrative decisions are linked to the distribution of power in society. The implications of this for theorising the state will be considered in chapter 3.

The advantages of a materialist approach to a theory of public facility location are therefore threefold. By emphasising that human beings (e.g. NHS planners) are not totally free agents, such an approach directs attention to the relationship between agency and structure. Planning cannot simply be explained by reference to the intentions of key 'managers', though this is not to deny the importance of attempting a comprehensive reconstruction of the planning process. Secondly, in considering the relationship of the state to the economy, it is not adequate simply to treat this mechanistically as a reflection of the economic base; as will become evident in chapter 3, the picture is a rather more complicated one. Thirdly, a class analysis of society is essential; given that a discussion of events in capitalist society is being presented, moreover, it is important to ground analysis of the state in the capital relation (cf. Holloway and Picciotto, 1977). It is important, finally, to outline briefly the way these remarks contained in this chapter offer an advance on the proposals presented by Dear.

Firstly, as argued above, Dear's case could have been strengthened which would have allowed him to base his reformulations on firmer foundations. As they stand, his proposals seem to allow him to retain a space for the positivist approaches roundly - and correctly - criticised in his papers. More
fundamentally, however, the case for and advantages of a materialist approach require a firmer grounding than Dear provided. For instance, in relation to the three aspects of materialism outlined, there is - firstly - no conception of the relationships of agency and structure, apart from a proposal to interpret location decisions in the context of the wider social formation. Secondly, Dear's view of the superstructure is mechanistic, in-as much as patterns of public service provision are seen as being inextricably determined by the socio-economic context in which they are set. Finally, at no point in his theory of society does Dear specifically point towards a class analysis of society apart from a proposal to 'clarify the links between public policy outcomes and the capitalist social formation', (Dear, 1978a, 110). Though Dear's views do provide a point of departure for an alternative theory of public facility location, this chapter has sought to indicate in which way further refinements are necessary. The final part of this chapter now reviews the foregoing evidence and argues that the proposals of section 2.4 offer a more fruitful approach to public facility location problems than the work reviewed in section 2.3

2.5 **Summary**

Section 2.2 presented a selective review of previous work on public facility location, and this work was evaluated in section 2.3. It was argued that notwithstanding the high level of technical sophistication attained by mathematical analyses of public facility location, such approaches were ultimately unsatisfactory. This was because they could not incorporate into their analyses all of the multifarious elements pertinent to their object of study, and because they suffered from theoretical
problems internal to their mode of construction. Nor had attempts to consider political and distributive aspects of facility location been entirely successful, due both to problems of measurement and to the lack of an adequate framework within which to account for the issues raised. It appeared therefore, that a comprehensive theory of public facility location had not been developed, and that - more fundamentally - such a theory could not be developed in the context of regional science within which much previous research had been conducted. Hence it seemed that an alternative approach to theory was required.

In this context the proposals offered by Dear (1978a, 1979) were reviewed (section 2.4). It was argued that certain refinements to these were necessary in order to provide a materialist theory of society; the relevance of these refinements will become more apparent in Chapter 3, in reviewing theoretical perspectives on the state. It is proposed that the approach advocated has at least two important advantages.

Firstly, a more comprehensive approach to the problem is provided. For example, it is possible to link the pattern of public service provision, with its attendant distributional consequences, to the political aspects of decision-making processes, and to link these, in turn, to the class character of the state. This is also more comprehensive, it may be noted in passing, than Kirby and Jones' (1982) agenda for public services research, which simply seeks the identification of links between social policy and its social and spatial outcomes. Irrespective of whether social and spatial issues
can be separated as easily as this, such a proposal clearly takes as given the nature of the determinants of social policy. Furthermore, by emphasising the constraints under which the planners of public services have to operate, and the conflicting demands which they must attempt to satisfy, the theory advocated breaks with consensus views of society. In contrast to those analysts of facility location who seem to assume that spatial reorganisation of service provision (e.g. Mayhew, 1979) is a relatively straightforward task, such an approach argues instead that conflicts over urban land use are such as to render the insights of mathematical modelling procedures of limited value. Finally, the views presented here allow an account to be given of spatial changes over time; this is an extremely difficult task within the static conception of theory which typifies much regional science, but by focusing upon broader social changes and their implications for public service provision, it ought to prove possible to understand how spatial patterns change through time.

Secondly, if explanation in the human sciences is viewed as the:

'making intelligible of observations or events that cannot be readily interpreted within the context of an existing theory or frame of meaning' (Giddens, 1979, 258).

then the proposals advanced address several issues not considered in previous research. Rather than analysing society at the 'level of appearances', for example, an attempt is made to link appearance - changing patterns of public facility provision - to the 'underlying social reality', that is, to broader historical changes in the British economy and society in the
post-war years. Moreover, the complexities of public policy formation and planning - which have received relatively little attention - are capable of incorporation and interpretation within the framework advocated. Likewise the relationship between the state and the economy, and the class character of the state, may be elucidated. It therefore appears that the reformulation of public facility location theory advocated here is necessary - given the unresolved problems of previous work - and is also progressive in terms of the comprehensive theory offered and the number of previously unresolved problems which can be addressed. Chapters 4-10 will exemplify this empirically, but prior to that, an evaluation is necessary of the extensive debates on the role of the state, since an adequate theory of the state is a crucial prerequisite of an understanding of public facility location. Chapter 3 therefore presents an assessment of various theories of the state.
3. The role of the state: competing theoretical perspectives

3.1 Introduction

The previous chapter emphasised the limitations of previous work within human geography on public facility location and, in seeking an alternative, advocated a fuller consideration of the role of the state. Until recently this subject has received scant attention from geographers (for exceptions, see Anderson, 1978; Dear and Clark, 1978, 1981; Harvey, 1976; and various essays in Dear and Scott, 1981, and Burnett and Taylor, 1981), and there has been limited consideration of the various theoretical positions on the state, though several studies of state intervention in regional development and planning (Cooke, 1980, 1982; Hudson, 1976, 1979; Lewis, 1982) are correcting this imbalance. As was argued above (chapter 2), explanations of the distribution of public facilities have also avoided confronting the debates to be reviewed here. Attempts to develop a theory of the local state (e.g. Dear, 1981; Kirby, 1979; Saunders, 1979) to account for spatial variations in state provision of services have been subject to criticism, not least because of the implicit functionalism and superficially radical rhetoric of the term 'local state'. More seriously, however, such work should be grounded in 'abstraction of social relations, rather than models of structure and institutions'; it has been claimed that perhaps the most influential texts on the local state (Cockburn, 1977; Saunders, 1979) are deficient in this respect (Duncan and Goodwin, 1982, 81).

It therefore seems that there is considerable scope for the
enrichment of research by geographers on such issues. One way to achieve this is to evaluate the variety of theoretical perspectives on the state; this is attempted in section 3.2, in which a brief introduction (section 3.2.1) outlines the criteria against which alternative views will be assessed. Pluralist and managerialist views are then examined (section 3.2.2) and are judged inadequate (in themselves) for a full understanding of state policy formulation. The claims of a variety of Marxist perspectives are then considered (section 3.2.3), and attention is directed to some important developments; in particular the work of Offe receives detailed consideration (section 3.2.4). A brief summary (section 3.2.5) is then followed by some comments on problems of empirical research within, and explanatory problems associated with, the theoretical views favoured. This chapter therefore commences by reviewing some competing theoretical perspectives on the state.

3.2 The state: competing theoretical perspectives

3.2.1 Introduction

This section selectively reviews some of the major positions on the role of the state; an exhaustive account would be beyond the scope of this thesis (see Frankel, 1979; Held and Krieger, 1982; Jessop, 1977, for fuller discussions). Alternative positions must be evaluated in terms of their appropriateness to the task of theorising the role of the state and its relationship to the organisation of society. More specifically, a framework is required which will facilitate an understanding of decision-making within the state; only in this way can an adequate interpretation be provided of policies on the provision of hospital services. Put another way, if a
reformulated public facility location theory has to discuss 'location decisions in the context of the wider social formation' (Dear, 1978a, 99; see also section 2.4) then it is essential to establish how this wider social formation to be conceptualised. Two questions therefore seem to be of particular importance. Firstly, is there any necessary class bias to state policy formulation and the exercise of state power? If so, what form does this take and how can it be identified empirically? The major theoretical distinction to be made here is between pluralist and managerialist views - which assert that no such bias exists - and Marxist arguments, which lay a central emphasis on the class character of the state. Secondly, by what logic does the state operate? What are the rules according to which its policies are produced? Is the operational rationality of the state equivalent to that of a private firm or does a rather different logic apply? If there is a class bias to the nature and operations of the state apparatus, how is it manifest in policy formulation? It is with these points in mind that pluralist and managerialist views of the state are now reviewed.

3.2.2 Pluralist and managerialist views of the state

These approaches share certain limitations in terms of theorising about society and the state. The pluralist view rejects any argument that class is the main line of cleavage in society and hence denies any notion of class bias in the actions of the state. This view may be characterised as presenting no more than an idealised description of how society currently works. The managerialist view tends to emphasise
the autonomy of key decision-makers, at the expense of a consideration of the constraints upon these individuals and upon the state. Their common failing, then, is that they deny any connection between power and class.

It has been suggested that 'a central, if not the central, tradition in Anglo-American political science has elaborated and defended a pluralist conception of society' (Held and Krieger, 1982, 1 - emphasis in original). Such a view - exemplified by the work of Dahl (1961) - defines power in voluntarist terms as the ability of an individual (or group) to act in such a manner as to control the response of another individual (or group). Power thus hinges on the exercise of control over immediate events. Pluralists assess the exercise of state power as part of a refutation of the argument that western capitalist countries are dominated by an economic elite or class; their case is predicated on four assumptions.

Firstly, pluralists claim that class divisions are neither the sole nor the major line of cleavage within society. Other factors (for example religion or education) are equally significant and, since all overlap to some extent, no one group can become dominant. Secondly, while the existence of political inequalities is recognised, public policy outcomes are assumed to represent differences in intensity of preferences rather than differences in power. Thirdly, the neutrality of the state between interest groups is allegedly guaranteed by the electoral process. If society (according to the first of the assumptions discussed here) is disaggregated into a number of minority groups, the electoral system will guarantee that no one group will establish control over the state. Finally, it
is assumed that there is no systematic bias in the exercise of state power, as the political system is grounded in a consensus which belies any notion of class domination. This rests on the assumption that any regime based on coercion cannot survive, because the electorate will react against the government in the next election. Party politics is said to be crucial in defusing economic conflicts and building up such a consensus (MacPherson, 1973, 191; see also Bevan, 1952).

The result of holding these assumptions is that as Dahl (1961) attempted to demonstrate with reference to local politics in New Haven, power in society is disaggregated and non-cumulative. While some groups might be disadvantaged in some situations, they would possess advantages in others. Although conflicts exist over appropriate allocation procedures for different resources, the process of bargaining guarantees equilibrium, and ensures that political outcomes are beneficial to the mass of the population. The desire for power over others is taken to be a natural human inclination; competition between interest groups is therefore an essential and inevitable aspect of politics. No one group will gain ascendancy over others, because it is assumed that considerable overlap exists between them and so each group, individually, is relatively weak. Hence the state is seen as a 'pawn up for grabs between competing contenders for political power' (Saunders, 1979, 151). From such a perspective, policy analysis typically focuses on who participates in decision-making, who gains and loses from various possible outcomes and who prevails in decision-making (Polsby, 1963, 4), often proceeding to a consideration of the extent to which decision-making corresponds to some ideal-
typical model of policy formulation (for example Allen (1979) and Ham (1981) apply such a methodology to NHS planning). Yet such approaches risk neglecting the broader social context of the issues they address (Navarro, 1976). The limitations of these approaches will be discussed below, following an examination of two arguments which, though critical of pluralism, ultimately do not transcend the framework within which it is set.

Firstly, pluralist views ignore the possibility of social and political constraints on the expression of demands within the political system. Bachrach and Baratz (1962) point towards this in discussing the process of 'non-decision making', whereby certain issues are selectively excluded from public debate. However, since their analysis is conducted at the level of individual actions and attitudes, it ignores the broader social context of non-decision making (McEachern, 1981, 12), though it avoids the 'one dimensional' approach to studying the exercise of power (Lukes, 1974, 15), which merely equates power with decision-making.

Secondly, Lukes (1974) introduces the notion of individual and group interests in decision-making, defining power as the capacity of a social actor to influence another in a manner contrary to the latter's interests. Yet power is not only exercised when the outcome is contrary to the interests of an individual or group; it may also be exercised where the outcome is irrelevant - or even beneficial - from the point of view of those not exercising it (Giddens, 1979, 89-90). Furthermore Lukes may not adequately connect power, interests and class, since he does not accept that interests are related to -
though not necessarily determined by class. Indeed, on this point, the views of Lukes and Dahl converge, denying the existence of any necessary connection between power and class (McEachern, 1981, 17) and so it is appropriate to reconsider the assumptions which collectively underpin the pluralist view and the claim that there is no class bias to the exercise of state power.

The assumption that class is neither the only nor the major line of division in society may be justifiable in particular circumstances, but it is surely not the case that other attributes are equally important or that - if so - they are always at least as important as class. Different classes, moreover, are clearly able to influence state policy-making to different degrees (see Miliband, 1969).

Secondly, the argument that policy outcomes reflect not differences in power but rather differences in the intensity of preferences of particular groups, ultimately reduces to the assertion that groups exert influence when they have a reason to do so, and the more influence they exert, the greater is their preference for a given policy outcome. Yet this ignores the possibility that a group may have an intense preference for a particular outcome and yet be unable to do anything about it.

Thirdly, the view that the neutrality of the state is guaranteed by the electoral process is problematic in that it presumes that self-interest is the basis of democracy. Put another way, although electors and elected pursue their self-interested goals the interests of the latter constrain them to act according to the preferences of the electorate. Furthermore, such a view presupposes a reasonable degree of political
sophistication on the part of the electorate. However, in opposition to this, it has been claimed that the electorate's position is such that they do not effectively raise or resolve political issues; they simply accept or reject those who are to rule them (Saunders, 1979, 153).

Finally, the claim that there is no necessary connection between class and state power because the political system is grounded in a consensus which belies any notion of class domination ignores central issues such as the role of ideology. For instance, groups may be able to manipulate the way policy options are presented and discussed in order to make their own interests appear to coincide with the 'general interest' (Anderson, 1973). Moreover, the question of 'effective political demand' receives little consideration; it is demonstrable that particular groups may have intense preferences and yet be unable to express them.

Thus the pluralist claim that there is no class bias or basis to power in society and the state is untenable, reflecting a more general problem of such views. For they take as their point of departure the empirical question of what characterises democratic societies. The elements identified are then developed into an:

'idealised description of... particular political systems, serving to elevate every element of these systems into virtues, and to justify what they find by ad hoc rationalisation'.
(Saunders, 1979, 156)

Hence such accounts merely provide an organised largely uncritical, description of the existing political system. A critique of such views can either confront them at an empirical
level, by presenting detailed evidence of systematic class bias in the policies of the state and the composition of its personnel (e.g. Miliband, 1969), or seek to demonstrate the structural necessity for the connections between the dominant classes and the state (e.g. Poulantzas, 1973); such approaches will be considered below. Before that, however, it is appropriate to evaluate the managerialist view of the state; not only has this received much attention within the geographical literature, but it also shares common ground with the pluralist view.

Managerialism's roots may be traced to Weberian sociology and, in particular, to Weber's arguments that firstly, there is no necessary connection between economic classes and political power, and secondly, that the mode of political domination in modern societies is increasingly - and necessarily - bureaucratic. The state is allegedly based on a monopoly of physical coercion sustained by a belief in its legitimacy. Bureaucracy and bureaucratic procedures attain a dominant position in the state apparatus by virtue of their technical superiority over other forms of organisation; hence considerable power accrues to bureaucrats by virtue of their expertise, information and access to secrets, and it is claimed that the bureaucracy is independent of, and neutral with respect to, class interests (Held and Krieger, 1982; Leonard, 1982). Such views have been influential in geography principally through the work of Pahl (1969; 1975), who proposed that inequalities in the socio-spatial system could be accounted for as a result of 'inevitable' spatial inequalities (due to the location of - for instance - services at discrete points (Harvey, 1973, 59)), which were mediated by the activities of 'gatekeepers' or 'managers'. For Pahl, both spatial and social constraints
existed on access to services, and the latter constraint:

'reflect(s) the distribution of power in society and...(is) illustrated by: bureaucratic rules and procedures (and) social gatekeepers who help to distribute and control urban resources'

(Pahl, 1969, 146)

Explanation of inequalities in public service provision is therefore pitched largely at the level of the values and actions of those who manage service provision. Although several interesting studies of the activities of urban managers have been provided (Duncan, 1976; Gray, 1976; Leonard, 1980; Moon, 1981) at least two problems remain.

Firstly, since managerialist views have inherited the Weberian argument that there is no connection between power and class, they lack a theory of power and so possess no firm theoretical grounds on which to base identification of key decision-makers. Hence it has been argued that managerialism simply focuses on descriptive data gathering, concerned with the activities of those who are assumed to have power (Norman, 1975). Secondly, the notion of the increasing domination of the bureaucracy has led to a stress on the internal operations of the state rather than - or at the expense of - discussion of external political pressures (Leonard, 1982, 192-193).

Hence managerialism fails to theorise the autonomy of managers. Put simply:

'in concentrating on studying the allocation and distribution of "scarce resources"...(managerialism) fails to ask why such resources are in short supply.

(Gray, 1976, 33 - emphasis added)

While of value in directing attention towards the degree of autonomy enjoyed by decision-makers within the state apparatus, it seems that managerialism can say little of more general
relevance unless it considers the relationship between the actions of managers and the social context in which they are set.

The approaches reviewed thus far, then, are of limited value even as starting points for examining the role of the state. The pluralist view presents little more than an idealised - and arguably inaccurate - description of society, while the stress of managerialist views upon individual action, and their limited consideration of constraints on the autonomy of managers, likewise restricts their value. Furthermore, since both approaches implicitly reject the notion that power and/or interests are structurally located (though not determined) the possibility of systematic class bias in the exercise of state power is ruled out. In view of these problems, an examination of debates on the state within Marxist circles ought to be fruitful; since these present a class analysis of society and focus on the constraints on state activities, they ought to assist in overcoming the problems identified here.

3.2.3 Major themes in Marxist thought on the state

The recent 'rediscovery' of the state as a problem in political economy has prompted extensive debates (summarised in, inter alia, Frankel, 1979; Gold et al, 1975; Held and Krieger, 1982; Holloway and Picciotto, 1978; Jessop, 1977; Mosley, 1982). In the light of the claims that public facility location theory should be reformulated as a 'theory of society' (Dear, 1978a; see chapter 2), the arguments presented above (section 3.2.2) have at best been only partially successful; they have merely offered descriptions, at an
empirical level, of how society currently works. By contrast, the importance of the views discussed here lies in their conceptualisation of society and of the relationship between the state and society. This is carried out with varying degrees of success, however, and so it is appropriate to begin by specifying criteria against which the adequacy of theories of the capitalist state may be judged.

For Jessop (1977, 353-354) five criteria should be fulfilled by a Marxist theory of the capitalist state. Such a theory must be founded on the specific qualities of capitalism as a mode of production. Secondly, it must attribute a central role to class struggle in the process of capital accumulation. Thirdly, the relations between the political and economic spheres of society must be established without reducing one to the other, or treating them as totally independent and autonomous. Fourthly, it is necessary to allow for historical and geographical differences in the form and functions of the state; there can be no universalistic theory of the capitalist state 'in general', since the state takes on different forms within specific social formations. Finally, non capitalist groups and/or non-class forces may influence the nature of the state and the exercise of state power.

Though these criteria are felt to be generally satisfactory, two additional ones can be proposed. In the light of the arguments of the previous section - that pluralist and managerialist views deny any connection between power and class - it is important to establish the class character of the capitalist state and the way this is manifest in state policy formulation. Moreover, since the emphasis of this research is on decision-
making by the state, the chosen theoretical framework must be capable of providing insights into the logic of state policy formulation, thereby facilitating an interpretation of the decisions which create spatial patterns of public facilities. Perhaps the easiest entrée into contemporary debates on the state is via a consideration of the contributions of Miliband (1969; 1970; 1973) and Poulantzas (1969; 1973; 1976). Their positions will be summarised and major points of criticism outlined.

Miliband's argument is referred to as instrumentalism: that is, the state is simply a tool of the capitalist class and will therefore advance the interests of that class. His work is essentially an attempt to refute, on empirical grounds, the pluralist claim that the state is neutral with respect to different classes; to do this, Miliband demonstrates the extensive interpersonal connections between the capitalist class and the state. Yet by arguing purely in empirical terms, Miliband does not advance Marxist analyses of the state; indeed, it is not uncharitable to suggest that Miliband sees the state as a pressure-influenced body which happens to favour the capitalist class simply because that class has greater strength than labour (McEachern, 1981, 27). However he does deploy two rather more sophisticated arguments, namely that inter-personal connections between the capitalist class and state personnel give rise to a shared 'world view' which shapes the way the state acts (Miliband, 1969, 55-69, 107-115), and secondly, that the state's insertion into a social formation dominated by capitalism ensures its class character, for the parameters within which state policies may be formulated are set by the limits of capitalist 'reality'
Though Miliband does point to the class character of the state, he has been subject to criticism on various counts. These include the charge of empiricism (Offe and Ronge, 1975, 137) and (concomitantly) the failure to situate his work within an appropriate 'problematic', whereby the class character of the state could be revealed other than on empirical grounds (Poulantzas, 1976, 64; Gold et al., 1975, 35; Clarke, 1977, note 1). Furthermore, Miliband does not adequately establish the processes whereby the 'strategies and actions of ruling groups are limited by impersonal, structural causes'; thus state power is conceived of in voluntaristic terms (Gold et al., 1975, 35).

Instrumentalism has made a valuable contribution in pointing to the systematic links between the capitalist class and the state. Ultimately, however, it reduces to little more than a radical managerialism, a demonstration that 'bourgeois theorists have got the facts wrong' (Holloway and Picciotto, 1978, 5), because of the lack of a rigorous theoretical demonstration of the structural necessity for these links.

Instrumentalism has usually been opposed to the structuralist analysis of Poulantzas (1969; 1973; 1976) though this is a rather arbitrary opposition; what is common to both Miliband and Poulantzas may be as significant as the differences between them. Poulantzas' initial response to Miliband highlighted the latter's neglect of the structurally-necessary links between the dominant classes and the state elite, and emphasised that Miliband had simply analysed the state in terms of the individual subjects who control it. By contrast, for Poulantzas:
'the direct participation of members of the ruling class is not the cause but the effect, and moreover a chance and contingent one, of this objective coincidence'

(Poulantzas, 1969, 73)

Poulantzas therefore takes as his point of departure the class structure of society and the contradictions inherent in a capitalist economy, and analyses how the state attempts to manage and/or displace such contradictions in helping to reproduce capitalist society. Since the central economic contradiction under capitalism is that between the increasingly social character of production and the continuing private appropriation of surplus value, two political threats may be posed to the unity of the system: working class unity and capitalist class disunity. To counter these, the state's role is that of a factor of cohesion (Poulantzas, 1973, 44-50): it attempts to guarantee the political organisation and/or unity of the dominant classes, and the political disorganisation of the working class (Poulantzas, 1973, 287-288). Only if the state is relatively autonomous from particular capitalist interests can it accomplish such a task; were it the tool or instrument of any particular capitalist group it would be incapable of doing so (Poulantzas, 1973, 256, 261-262, 282, 284-285). Moreover, the state should not be seen as a monolithic bloc; it is itself an area of conflict, and the precise level of autonomy accorded to it depends upon the intensity of struggles over it and upon relations between classes. There are, however, several problems with such views.

Firstly, while Poulantzas shows that a relatively autonomous state protects the interests of dominant classes, and that the state must be relatively autonomous if it is to act as a factor
of cohesion, he does not adequately account for the social mechanisms which guarantee that the state will act in such a fashion (Gold et al., 1975, 38). Secondly, this analysis is functionalist and tautological, attributing events in society to system needs which are accorded an explanatory status without their existence being accounted for (Clarke, 1977, 21; Giddens, 1982, 215). Thus concepts such as 'relative autonomy' are accorded the status of quasi-independent variables, which can be deployed in an explanatory account of virtually any historical situation (Saunders, 1979, 184); hence Saunders' complaint that the structuralist position is impossible to falsify since it rules out the possibility of counter-factual argument. Finally, an insistence on the relative autonomy of the economic and political spheres appears to be used as a justification for treating the two as separable objects of study. Hence, the relationships between the two may be neglected, thus sidestepping the problems of relating political developments to the contradictions of capitalist economic development, and failing to consider adequately such issues as the scope of and limits to state intervention (Holloway and Picciotto, 1978, 5-7).

Thus instrumentalist and structuralist approaches are both limited in terms of their ability to account for the class character of the capitalist state. Since both insist upon the separability of the political and the economic, neither explicitly confronts the problem of the limits to state intervention, and in particular those constraints imposed by the necessity to guarantee continued accumulation (Jessop, 1977, 361; Holloway and Picciotto, 1978, 7). Hence the extent to which either author's perspective can be employed to elucidate the class character of state policy is limited. An instrumentalist account is restricted to discussing this at the level of interpersonal connections
while for adherents of Poulantzas' views, the concept of relative autonomy can be brought on in virtually any historical situation to account for the complexities of state practice. In order to progress away from such ultimately restrictive viewpoints, the next section will evaluate more recent theoretical statements, concentrating, in particular, on the work of the 'state derivationist' debate and examining the contribution of Offe in some depth.

3.2.4 Recent advances in Marxist theories of the capitalist state

The analyses reviewed above exhibited various limitations concerning their ability to elucidate the character of the capitalist state. Consequently this section identifies certain developments in Marxist theories which can assist in this task and also illuminate state policy-making. Drawing on attempts to derive the form and functions of the state from the characteristics of the capitalist mode of production (Holloway and Picciotto, 1977; 1978), this section first discusses the contribution of capital-logic accounts of the state, before presenting the views of Habermas and, in particular, Offe, in some detail. In contrast to Miliband and Poulantzas, for whom the class character of the state depends on factors external to the state itself (Jessop, 1977, 361), the state derivationists have sought to elucidate the intimate relationship between the form and functions of the state and the characteristics of capitalism as a mode of production.

One of the less sophisticated arguments within the state derivation debate has been the 'capital logic' position
(exemplified by Muller and Neususs, 1975; and the essays by Altvater and Blanke et al in Holloway and Picciotto, 1978). The state is seen as an 'ideal collective capitalist', a political institution corresponding to the common needs of capital and providing that which is required for capitalist reproduction yet which cannot be guaranteed through competition between capitals (Altvater, 1978, 42; Muller and Neususs, 1975, 77), as well as being responsible for providing general conditions for the existence of capitalism (such as legal and monetary systems - Blanke et al, 1978). Though such accounts claim to accord primacy to class struggle in their analyses, this struggle is nonetheless 'informed and bounded by the exigencies of capital accumulation' (Holloway and Picciotto, 1977, 92; see also Muller and Neususs, 1975, 79). While a capital logic approach establishes that the state is not a simple and/or undifferentiated instrument of capital (since, in acting in the common interests of capital, the state may have to intervene against individual capitals), this view ultimately deploys the reductionist argument that everything that happens in a capitalist society necessarily corresponds to the needs of capital (Jessop, 1977, 364).

In response to such problems, attempts have been made to introduce an awareness of historical specificity into analyses of the capitalist state, emphasising how the character of the state has changed in response to the changing circumstances occasioned by the development of capitalism (Holloway and Picciotto, 1977, 85-97; Mandel, 1975, 474-479). In addition, the work of Habermas (1976a, b), Hirsch (1978) and Offe (1974; 1976) provides important insights into the importance of class struggle in shaping the capitalist state. From a different
point of departure, theorists such as Gramsci (1971) have reached important conclusions concerning the class character of the state, and the manner in which the dominant classes secure and maintain 'ideological hegemony', as mediated through the state. Yet such a class-theoretic approach ultimately fails to consider the problems of the limits to state intervention (Holloway and Picciotto, 1977, 82; 1978, 3), though it may be that the area of ideology and consciousness is one in which the analyses reviewed here could be strengthened. Bearing this in mind, it is now argued that the awareness of class struggle provided by the theorists reviewed here is of central importance on four counts.

Firstly, the 'laws of motion' of capitalism are not natural or inevitable; they are at best tendential (Mandel, 1975, 19), and are intimately related to the balance of class forces between capital and labour (Hirsch, 1978, 74). In failing to recognise this, capital-logic accounts of the state (e.g. Muller and Neususs, 1975) are ultimately ahistorical (Holloway and Picciotto, 1978, 22). Secondly, since capitalist social relations must be presented as formally free, equal, and organised without coercion, relations of force must be abstracted from the immediate process of production (Hirsch, 1978, 61-64). Thirdly, there is no necessary and automatic correspondence between state intervention and the needs of capital (contra capital-logic views) and so crises in the accumulation process are of central importance in re-shaping the form of state intervention as well as in exposing the class character of the state (Offe, 1974, 45). Fourthly, crises are the result of various contradictory factors which affect different groups in different ways; hence there are no simple solutions to crises. Rather the state responds to crises in
an ad hoc, trial-and-error fashion (Habermas, 1976a, b; Offe, 1976).

Hence important insights are provided into the nature of class struggle. Moreover, important analyses of the implications of the structural features of the capitalist state for policy formulation are provided, particularly by Offe (1974; 1975a, b; 1976; but see also O'Connor, 1973; Habermas, 1976a, b; Hirsch, 1978). In general terms, the capitalist state must attempt to maintain capitalist accumulation and ensure the legitimacy of this process. The state can therefore be characterised as an input-output mechanism (Dear and Clark, 1981, 55; Habermas, 1976b, 375); its output consists of its sovereignly executed administrative decisions, for which it requires an input of mass loyalty. Failure to maintain the necessary inputs or outputs may lead to crises. If the state does not fulfil the steering imperatives which it has taken over from the economic system, there may be a rationality crisis, manifest in a divergence between the intentions and outcomes of state policies, or as a perceived paradox in the logic of policy formulation. On the other hand, the state may fail to maintain the level of mass loyalty essential to the pursuit of these goals, leading to a legitimization crisis (Habermas, 1976a, 45-94). Both tendencies may be compounded by the fiscal crisis of the state; that is, the tendency for state expenditures to exceed revenues (O'Connor, 1973). These views have only been sketched here (see Jessop, 1977; Frankel, 1979; O'Connor, 1973; Habermas, 1976a, 45-94 for fuller discussions), but of more direct relevance is their deployment by Offe in his analysis
of the state's capacity for rational administration.

If the state is to satisfy the competing imperatives and demands placed upon it, Offe claims, it must both simultaneously intervene in the economy and conceal its purpose; if this were not concealed, there would be a challenge to the normative acceptance of market rationality, thus casting doubt upon the class neutrality of the state. The state is therefore defined by four characteristics.

Firstly, it is excluded from accumulation; it cannot be seen to compete with individual capitals, nor can it replace them. Secondly, it is necessary for accumulation, since it must take over more and more aspects of the economy that are essential to accumulation but which cannot be provided by private capital; in this sense the state acts as a collective capitalist (Offe, 1975a, 126). Thirdly, the state is dependent upon accumulation so as to ensure the availability of revenues adequate to the performance of the state's tasks (Offe and Ronge, 1975, 139; Hirsch, 1978, 104). Finally, the state must deny these functions in order to ensure legitimacy for its policies; rather the state attempts to secure assent for its interventions by presenting these as being in the general interest of all groups in society. For Offe, the extent to which the state can carry out these tasks is extremely problematic (Offe, 1975a, 144). This brings him to the problem of state policy formulation and he makes two major contributions. He identifies a variety of mechanisms whereby policy options are chosen, and he considers the logic according to which policy formulation takes place.

On the former point, Offe distinguishes the operations of the state in liberal capitalism - where its activities are of
an allocative character - from its interventions in late capitalism, which he characterises as being of a productive character. The allocative mode, in which decisions have to be taken concerning the use of resources already owned by the state, is one in which operational goals are clear cut; they can be derived from manifest interests and power relations. However, in a productive mode of intervention, the state is increasingly involved in the production of goods and services; since this raises a considerable number of issues regarding the nature and scope of such intervention, the application of bureaucratic procedures is inadequate (Offe, 1975a, 133; Offe and Ronge, 1975) and the state selectively favours certain groups whose acquiescence and support are considered essential to the preservation of the existing social order (Held and Krieger, 1982). Various selection mechanisms exist which, according to Offe, confirm the class character of the state.

Firstly, positive selection mechanisms allow the state to:

'sandardise and reduce to its essence a collective capitalist interest... even in the face of empirical opposition from competing capitals' (Offe, 1974, 38).

Thus the state has to anticipate and mitigate the effects of short-sighted competition between capitals. Two points should be noted. Firstly, positive selection mechanisms may be both productive and allocative in character; currently welfare services in Britain are dominated by productive intervention (e.g. the NHS) though this is not to deny that allocative intervention (in the form of minimum safety and health standards, for example) is still in force. As indicated above, then, the scope and character of state intervention will vary historically.
Secondly, on an **ideological** level, there are limits to the scope of possible policy formulation; ideological selection processes may give rise to a disjunct**ure between what the state could do and what it actually does (Offe, 1974, 39). This is not to suggest that ideology operates in some blind, mechanistic fashion; if ideology is seen as a system of ideas which serves sectional interests by presenting them as being in the general interest (Anderson, 1973, 5), it is reasonable to suggest that the processes whereby ideologies come to be accepted are very complex. It is perhaps in this respect that Offe's work is weakest (Frankel, 1979, note 15; Jessop, 1977, 366-367), yet there is at present 'no wholly satisfactory theory of ideology' (Centre for Contemporary Cultural Studies, 1977, 5); essentially what is at issue is the establishment of what Gramsci (1971, 258, 261-264) terms ideological hegemony by the dominant classes or power bloc. Given these caveats concerning Offe's views, ideology - as a selection principle - is evident in what follows in two ways. Firstly, the way an ideology becomes accepted as legitimate may be of decisive importance in terms of sketching broad outlines of policies. Thus the current emphases on the unproductive nature of state expenditure in Britain have led to restraints on and attempts more rationally to control the use of such expenditure and this is evident in the exclusion from policy documents of objectives that may conflict with what are claimed to be the needs of the 'system' (see, for instance, the discussion of recent trends in hospital policy in chapter 7). Secondly the case of hospital planning for Newcastle upon Tyne exemplifies the use of a particular view of medical practice to present the arguments
Secondly, the quotation from Offe is reminiscent of a capital-logic view, yet it is clearly not the case that welfare services are provided solely to supply the needs of capital; such services are also demanded by, and are beneficial to, labour (Gough, 1979). This poses severe explanatory problems for historical accounts of the welfare state (see Harris, 1980).

As well as positive selection procedures, Offe also identifies negative selection, whereby anti-capitalist policy objectives are excluded. These operate on four levels: structure, ideology, process and repression. Firstly, the structural level incorporates the most general constraints on which issues become the subject of state intervention. Offe and Ronge (1975, 140-142) argue that the capitalist state can fulfil its contradictory objectives only if it can create conditions under which all economic actors can participate in commodity relationships. Hence one would, in principle, anticipate resistance on the part of the state and the capitalist classes to implement proposals for the provision of welfare services for use rather than exchange. The clearest example of structural selection in the context of this thesis would be the assumption - implicit in the wartime and postwar reforms of the welfare services in Britain - that the health services were to be organised within limits prescribed by the existing social order (Navarro, 1978, 38-48; see also chapter 4 (below)). Attempts currently being made under the present Conservative government to roll back the boundaries of state intervention would also fall in this category (for instance, facilitating the development of private health care), though it is clear that - as the rise in unemployment indicates - its overall economic strategy is some way from allowing all economic actors to participate in exchange relationships.
of sectional interests as being in the interests of all concerned (chapters 8-10).

The third selection procedure is that of process: the formal decision-making mechanisms and institutions of the state create the possibility that some interest groups will be favoured at the expense of others. Thus the class composition of health authorities in Britain may facilitate the reproduction of class inequalities in resource allocation (Crossman, 1972; Walters, 1980), though such procedures do not operate as mechanistically as Navarro (1978) appears to suggest. Thus the case studies of local planning issues (chapters 8-10) illustrate that certain groups were in a stronger position to press their claims than others. Likewise there are grounds for arguing that a proposed revision of the hospital plan (the Bonham-Carter Report - Central Health Services Council (1969)) exhibited a systematic bias in its proposals towards the interests of consultants, emphasising the virtues of centralisation of medical facilities and paying limited attention to such issues as accessibility (see chapter 6). Finally, Offe's fourth negative selection principle - the use of the repressive apparatus of the state - does not directly concern us here.

Thus Offe provides valuable insights into the means whereby the class character of the state is revealed by various positive and negative selection procedures, which operate at various levels. Offe also highlights the problems of pluralist and managerialist accounts of the state by analysing the adequacy of various methods of policy formulation in terms of accomplishing the tasks of the capitalist state. These are
the logics of bureaucracy (governed by Weberian purposive rationality), purposive action (governed by technical rationality), and a consensus mode (in which the determinant of administrative action is conflict over interests and/or agreement on common interests)—(the following summarises Offe, 1975a, 133-140). Bureaucratic rules and procedures—advocated by Weber on the grounds of their technical advantages (precision, speed, unambiguity and so on)—are appropriate when the state's role is limited to allocation. This is because decisions simply have to dispose of resources already owned by the state and hence decision-making can follow pre-specified criteria. However, increased involvement of the state in productive activities raises a whole host of problems. Since productive activities on the part of the state are, in the strict sense, market-replacing activities, the criteria according to which these are to be carried out are not subject to neutral, technical decision-making procedures. For instance involvement of the state in productive activities raises questions about the extent and purpose of state action, the most efficient way of achieving objectives and the distributional consequences of state policies. State intervention in health is a case in point. Allocative intervention involves making certain claims legal or setting minimum standards (for instance, legislation on the length of the working day, or on sanitation conditions in houses) and bureaucracies are ideally equipped to carry out the supervision of such legislation. Productive intervention, on the other hand, may involve such activities as the construction and management of public hospitals and so the state becomes directly involved in the organisation of physical
investment and equipment. Consequently the scope of events occurring outside the influence of the administrative apparatus is much greater and is beyond the control of technical, bureaucratic procedures. The setting up of the NHS, involving a considerably greater role for the state in terms not only of productive policies but also in terms of producing services for use rather than exchange, has posed serious problems for the state in controlling, justifying and distributing resources, and the multifarious claims on the service could not be resolved simply by recourse to bureaucratic procedures.

Alternative logics of policy production are that of purposive-rational action and that grounded in democratic conflict and consensus. The former presupposes that the state has clear-cut, unequivocal rules towards which it can move. This may well be true for the individual entrepreneur under conditions of competition (in the sense that, at the very least, one may assume a desire to stay in business); but the state must reconcile such diverse competing claims that the specification of precise operational goals is problematic. Even if such goals could be specified, there are severe constraints on the ability of the state to implement its declared intentions and attain its goals; witness the problems of implementing the 1962 Hospital Plan (chapters 6-10 below).

The final alternative 'logic' of policy production is that of allowing political conflict and consensus to determine the outcome of public decisions. However, the sheer problem of consensus formation would render the state incapable of long-term planning, not least because more demands and interests would be generated than could possibly be satisfied under
existing financial and institutional constraints (Offe, 1975a, 140). Hence policy formulation cannot admit or consider all possible demands upon the state and so some form of selection procedure is necessary. As has been indicated above, this will tend to favour certain classes and interests at the expense of others.

The consequences of accepting arguments are threefold. Firstly, they provide further grounds for rejecting pluralist and managerialist notions of the state. Irrespective of the technical competence of managers, and allowing for the influence of subjective factors in managerial decision-making (Gray, 1976; Leonard, 1980), in the final analysis too many events are beyond the control of managers. As far as pluralist views are concerned, the arguments advanced above have attempted to demonstrate that, far from all interest groups being in a position to articulate their demands, there exist systematic selection procedures which tend to structure decision-making procedures in certain ways.

Secondly, these propositions reinforce the arguments developed above (chapter 2) that the production of the kind of theory advocated for public facility location by several authors (for instance, Teitz, 1968) is an unrealistic project. Though it is, in principle, possible to specify operational goals appropriate to private sector location problems, this is not so in the public sector, due to the number of influences and issues to be considered and the problem of specifying the goals to be achieved.

Thirdly, it follows that the operational rationality of
the state is somewhat difficult to specify. The state must produce policies that have to take account of a range of economic, political and social considerations. For example, in evaluating the closure of a hospital, how would one assess the various implications, in terms of access to services, traffic flow patterns, employment opportunities and so on? Thus there are no clearly defined rules for policy formulation and, moreover, the state must submit to various constraints on its scope for manoeuvre. The capitalist state cannot increase its planning capacity to the extent that freedom of investment ceases, thereby subjecting private capital to political decisions. This is because of the need to justify state planning to the electorate; hence the state cannot act simply to solve the problems of capital. Nor can the state simply dispense with the production of services for use. Such services cannot be seen solely as a burden on private capital (e.g. Bacon and Eltis, 1976), for they provide important benefits to capital in terms of creating opportunities for exchange relationships (Gough, 1975; 1979). In between the extremes of central planning and laissez-faire, the state's activities are directed towards:

'cautious crisis management and long-term crisis avoidance strategy'
(Offe, 1976, 415).

The state seeks to defuse potential crises by seeking political solutions which, though neither unassailably 'rational' nor entirely arbitrary, nevertheless have the effect of compromising between the views of all interest groups, though the selection procedures discussed above will tend to skew the decision-making process somewhat. Purely technical solutions to state decisions are inadequate, precisely because
of the number of interest groups to be satisfied and due to constraints upon the state (Frankel, 1979, 222-225).

In the light of these comments, the detailed case studies of hospital planning (chapters 8-10) should not be seen as the finest empirical embodiment of a theory of the capitalist state in general, but rather as concrete evidence which supports these propositions. The issues discussed below illustrate the policy formulation process, the way the interests of certain groups take precedence in planning, the extent to which the views of all interested parties can be considered, and the way knowledge is produced in order to favour particular interests. In this respect Offe's work on state policy formulation is significant in that his views raise theories of the state to a level at which they are - at least in general terms - capable of providing reasonable interpretations of the complexities of hospital planning discussed below.

3.2.5 Concluding comments

This review has assessed the status of certain theoretical propositions of the state from the point of view of their validity as theories of society (Dear, 1978a; see also chapter 2, above). Two important issues were identified, namely the existence of any necessary class bias to state policies and the exercise of state power, and the character of state policy formulation. Pluralist and managerialist views (section 3.2.2 above) are inadequate on both counts. By denying any connection between power and class, pluralist views provide no more than an idealised description of how society currently works. Managerialist views lack an adequate theory of the relationship
between the actions of managers and the social context in which they are operating. In addition, as Offe graphically demonstrates, neither provides an adequate account of state policy formulation.

In evaluating Marxist theories of the state, this review has moved from a subjectivist approach (Therborn, 1978, 130-131), which merely locates who has power and describes the exercise of it, to an historical materialist view, seeking to understand the state as part of the process of reproduction of capitalist society. It would be valid to characterise what are often assumed to represent Marxist analyses (e.g. Miliband, 1969) as theories of the state in capitalism, or as subjectivist views; by contrast, more sophisticated writings have sought to derive the form and functions of the capitalist state from the wider structural relations of capitalist society. This has been achieved with varying degrees of success. Thus despite the points of difference between Miliband and Poulantzas, both attempt to establish the class nature of the state by concentrating on the specificity of the political with respect to the economic sphere, thereby ignoring fundamental economic constraints upon the capitalist state. Capital logic analyses are, in principle, an attempt to derive the form and function of the state from the laws of motion and historical development of capitalism, but they are ultimately reductionist and ahistorical in character. In response to such problems, Offe's work provides important theoretical advances. Stressing the historically changing character of the capitalist state, and the way this is mediated through class struggle, Offe (as well as Habermas) confronts attempts by the state to respond to the crises of capitalism. Moreover, Offe's analysis of the
selective character of state intervention, and on the logic of state policy formulation, is particularly valuable. These arguments appear to provide a means whereby the problematic and complex articulations of state policy may be interpreted not simply in the light of the idiosyncratic actions of key individuals or powerful groups, but rather in relation to structurally located characteristics of the form and function of the capitalist state. However, problems remain in employing such frameworks to interpret state policy formulation and the final section draws attention to some of these.

3.3 Problems of interpretation and theories of the state

This section draws attention to some of the problems in employing the theoretical frameworks favoured, referring principally to the relationship between theoretical categories and empirical evidence. This is not to deny that problems existed concerning the survival, availability, quality and reliability of this evidence but such matters have already been discussed (chapter 1). Nor will an attempt be made to confront two major theoretical problems pertaining to analyses of the capitalist state, namely the functionalism implicit in several views (Giddens, 1982, 215) and the teleological character of some historical accounts of the welfare state, whereby information is interpreted in a manner which suggests that the 'balance of class forces' was in some way inevitably right for whatever actually happened (Harris, 1980, 248). Several important interpretative problems cannot be ignored.

Firstly, some of the propositions reviewed are written at the level of the capitalist state in general, and while this
begs the question of the desirability of writing at such a level of abstraction, the point that the form and function of the capitalist state will be historically specific and contingent on various factors should require no further elaboration. (Frankel, 1979, 200; Jessop, 1977, 367). Moreover, conducting analyses at such a level of abstraction may lead to ignoring the importance not only of local aspects of social relations and state practice (Byrne, 1982), but also of supranational state institutions and organisations (such as NATO or the EEC). The interrelationships between the several levels of such a hierarchy pose an important problem for contemporary analyses of the capitalist state (Harris, 1980, 260).

Secondly, there is the need to relate the actions of individual decision-makers to such abstract theoretical formulations, especially in relation to the complex debates on local policy issues (chapters 8-10). Local autonomy in decision-making undoubtedly does exist, and it is in this sense that the actions of, and interpersonal and intergroup negotiations between, key policy formulators are worthy of close examination. It cannot be overemphasised that the selection procedures discussed by Offe do not operate with some kind of mechanistic inevitability; they will be modified in their operation by the complexities of local politics and planning. However, this is not to deny the prominence of certain class interests in the operation of the state even at this local level; nor does it exclude the possibility that the policy options available at the local scale may be constrained by selection mechanisms operating at a higher level; nor can the possibility be ignored that structural constraints on
the intentions of certain agencies of the state may generate a discrepancy, or lack of coordination, between the goals of these agencies, and (more generally) that social reformist intentions may become subordinate to broader economic imperatives. Hence, even at the local scale there is evidence which, in a variety of ways, poses the problem of the limits to state intervention and the extent to which the state can achieve certain ends. The theoretical frameworks outlined above therefore allow interpretations to be pitched at a rather higher level of abstraction than that of individual idiosyncrasy or autonomy and hence avoid the problems of voluntarism which can be associated with managerialist interpretations. Objective pressures and constraints arising from the contradictory nature of demands placed upon the agencies of the state are decisive, rather than the subjective wishes of key individuals. Since the theoretical statements discussed above provide a means of explicitly dealing with such constraints, there seems to be little danger in applying them in this context.

A third problem concerns the extent to which class interests can be identified. While Offe's views imply that chosen policy options in general favour capitalist interests and systematically exclude anti-capitalist interests, this seems to present classes as undifferentiated entities, yet this is patently not so. It is essential to recognise that sub-class groups exist and that these are all capable, to varying degrees, of articulating their objectives and influencing policy. In this sense, there is some force in Giddens' (1982, 216) claim that pluralist views have something to offer Marxist analyses, insofar as the latter must consider
explicitly the variety of interest groups making claims upon
the state (see also Harris, 1980, 258).

Fourthly, the relationship between theoretical categories
and empirical evidence may be problematic, partly because of
the variable quality of the latter and the level of abstraction
of the former, and partly because of the language in which
disputes are conducted and policies articulated. The manner
in which Parliamentary debates are conducted, for instance,
'slurs and mutes the deep antagonisms which exist in society'
(Bevan, 1952, 27); hence Parliamentary democracy may serve to
defuse class conflict. It may be that lapses and silences
in policy documents and the language in which they are written,
may be deliberate and systematic expressions of power relation-
ships in society; though this is not developed in great detail
below, this issue can ultimately be linked to debates on
language and explanation in the social sciences (on which see
Giddens, 1979; Foucault, 1971; 1973; 1975; MacDonald and Pettit,
1981). More specifically, the empirical identification of the
selection procedures referred to, poses serious problems if
one only has access to policy documents on an ex post basis;
in such a case, the researcher would be unable to examine
policy issues which had been excluded from consideration.
Reference could be made to a 'totality of abstract possibilities'
in order to assess the selectiveness of political institutions,
but the result would be that the negative concepts would
become:

'so multifarious and non-committal that the result is
the trivial statement that every conceivable form of
social organisation is based on exclusion rules',
(Offe, 1974, 45 - emphasis added).
Conventional political theorists have circumvented this problem either by restricting the scope of their enquiry to that which is empirically observable, or by acknowledging 'non-events' recognised by the system itself (e.g. Bachrach and Baratz, 1962). However, such non-events are in principle contingent and revocable (Offe, 1974, 42) so that such views are unable to account for the class character and selective nature of state policy formulation. These become apparent because of the competing demands placed upon the state; since these cannot all be conceded, due to the structural properties of the state, selection procedures will operate and, as argued above, these will tend to favour certain groups.

Finally, brief reference should be made to the relationship between theoretical and empirical research. Harvey's (1973, 128-129, 144-145) accusation that simply amassing information about social and spatial inequalities is of little intrinsic value, still rings true. In terms of seeking explanations of such inequalities, it is inadequate simply to amass evidence on decision-making without criteria upon which to base selection of empirical examples. Furthermore, considerable debate on the state has taken place at an abstract level with a 'regrettable disregard for empirical research' (Navarro, 1978, xvii). If the state's influence on spatial patterns is to be adequately understood, it is important to recognise the complementary nature of theoretical and empirical work (Sayer, 1979b). It is possible to make claims about the capitalist state in general terms, at a theoretical level, but precise articulations of state policy formulation are essentially
contingent matters and so must be revealed by empirical research. In what follows therefore, an attempt is made to illuminate the relevance of these theoretical propositions at two related levels. Firstly (chapters 4-7) major themes in the development of the acute hospital services of postwar Britain are examined. The emphasis here is on the changing character of the British state and the implications of this for the NHS and for hospital planning in particular. Hence, following a discussion of the evolution of the British hospital system, a broad overview is presented of issues in the planning of the hospital service since the war. Attention is directed specifically to events in the Newcastle RHB (Northern RHA from 1974) and to constraints on the ability of the state to implement its declared intentions, particularly in relation to local planning issues. Chapters 8-10 then exemplify various points raised in chapters 4-7, by examining in detail three disputes on hospital strategy. This material is treated thematically. Thus an attempt is made to link developments in intraregional spatial policy and hospital planning (chapter 8), focusing on the extent to which the intentions of various agencies were - or were not - coordinated. Then (chapter 9) examples are presented of the use of technical procedures for the resolution of local planning disputes; doubt is cast upon the utility of these in terms of providing solutions to policy problems. Finally, a detailed discussion is presented of the resolution of the conflicts referred to, illustrating the considerations given prominence in the planning process (chapter 10). The aim is not to 'test' explicitly the various views of the state
evaluated above, but it should become clear that the evidence further supports the discussion (above) concerning the relative merits of particular views. It is important to commence with an account of the development of hospital planning in Britain prior to 1948, in order to understand the nature of both the problems to be resolved and the proposals for their resolution; this account is now presented in chapter 4.
4. The evolution of the British hospital services prior to 1948

4.1 Introduction

This chapter is divided into three sections. The first (section 4.2) presents a brief account of the development of the hospital services in Britain prior to World War 2, focusing particularly on the gradual extension of state intervention in hospital provision. The bulk of the chapter (section 4.3) then examines proposals for the post-war hospital system and the conflicts over these; of particular interest here are debates on whether or not full state control of hospital services was necessary and/or desirable, and discussions on the arrangements for post-war hospital planning. Finally (section 4.4) the condition of the hospital stock inherited by the NHS is discussed so as to illuminate the difficulties to be resolved.

4.2 Historical background: state intervention and hospital provision before World War 2.

Two forms of hospital provision existed in Britain before World War 2: the voluntary and municipal hospitals. The former depended for financial support largely on private philanthropy, the motivations for which ranged from genuine charity to a desire for the social prestige derived from patronage of a hospital (Widgery, 1979, 3; Abel-Smith, 1964, 65). With the emergence, in the early 19th century, of what Foucault (1973, xix) has described as a 'new empiricism' in medical practice, there had developed pressures on voluntary hospitals to keep up with medical
practice and research. Hence the voluntary hospitals concentrated largely on the treatment of the acute sick and, given the social barriers on entry to the medical profession, the prominence of certain sectors of the health services was already being established (Abel-Smith, 1964, 16-31).

The second form of hospital provision was the municipal hospitals. State intervention in hospital provision dates back to the workhouse infirmaries incorporated in the 1834 Poor Laws. Given the 'less eligibility' principle on which these had been established (Doyal, 1979, 143; Widgery, 1979, 5), conditions in such facilities were generally poor and they were built cheaply, often on isolated and unhealthy sites (Allen, 1979, 10). Nor was there a direct duty on the state to provide hospitals: Poor Law legislation was discretionary rather than mandatory, and so there was no guarantee of hospital provision in any particular area.

However, there emerged pressures for increased state intervention in health matters in the late 19th and early 20th centuries; several public health acts attempted to cope with the rapid spread of infectious diseases. Furthermore, the implications of the urban environment of 19th century Britain for the health of the working population were graphically demonstrated in the poor physical condition of Boer War recruits (Doyal, 1979, 161-163). Such pressures, coupled with working class demands for reform (Navarro, 1978, 9-10), led to the social insurance legislation of the pre-World War I Liberal government. However, the major demands for reforms of the hospital service were to be articulated by defenders of the voluntary hospitals. Dependent on philanthropy, their development had been uncoordinated and
unplanned: location was determined neither by cooperation between voluntary hospitals, nor by a policy coordinated with municipal facilities (Allen, 1979, 11) and the consequences had been graphically revealed by a government inquiry (House of Lords, 1890-1892; see also Royal Commission on the Poor Laws, 1909). After World War 1, the increased militancy of the population led to demands (inter alia) for a comprehensive state health service (Navarro, 1978, 16-17; Doyal, 1979, 175), though these demands were subsequently diluted and defused. In particular, the government's initial proposals for the health sector (the Dawson Report - Consultative Council on Medical and Allied Services, 1920) merely favoured cooperation - rather than integration - of voluntary and municipal hospitals. Even these proposals were not implemented following the defeat of what Navarro termed the 'progressive wave' in British society in the 1926 General Strike (Navarro, 1978, 19; see also Coates, 1975, 21-25).

If working class pressures for reform had thus been defused, there was nevertheless substantial pressure from the voluntary hospitals for increased state financial support. The financial situation of these hospitals worsened considerably in wartime; from 1913 to 1920, their income had risen by 67% as against cost increases of 138% and 321 (out of 565) voluntary hospitals in England and Wales had deficiencies on normal income (Pater, 1981, 12; see also Pinker, 1966, 149-155), for a detailed analysis of the financial position of voluntary hospitals). In response, a block grant of £500,000 was allocated to the voluntary hospitals following the report of the Cave Committee (Ministry of Health, 1921), though this was to be a limited and temporary measure for fear of undermining public contributions to and support for the voluntary
system. Such resistance to greater state involvement was also evident in the rejection of the Onslow Committee's (Ministry of Health, 1928) call for a government grant towards the provision of additional hospital beds, and in attacks on Neville Chamberlain for recommending that a mechanism be set up for coordinating the activities of voluntary and municipal hospitals (see Pater, 1981, 14-15). Though the 1929 Local Government Act empowered local authorities to provide acute hospital services - an extension of their existing obligation to facilitate the treatment of infectious diseases - no formal steps were taken to guarantee the cooperation of municipal and voluntary systems: hence, 'the climate in many areas... was not so much one of cooperation as of cold war' (Pater, 1981, 16). However, such cooperation was increasingly perceived as essential; the interwar depression had adversely affected both local authority rate income and public contributions to voluntary hospitals and thus had hampered hospital development (see Mess, 1928, 116). Moreover, since the distribution of specialists was closely related to the potential market for private practice, areas such as the North East were likely to lag behind others in medical provision (see below, section 4.4). Hence the more effective planning of hospital services was an increasingly urgent problem; by 1937, even the voluntary hospitals were willing to accept increased state finance for hospital development (British Hospitals Association, 1937). However their views in no sense went as far as other contemporary documents (Department of Health for Scotland, 1936; Royal Commission on Tyneside Local Government, 1936), which respectively advocated centralised control of medical services, and regionalised local government in the interests of more
effective planning.

By World War 2, then, a consensus had emerged on the necessity for increased state involvement in hospital provision. This was a result of the convergence of very different political forces. Though there had initially been a somewhat negative response to the possibility of state intervention, particularly from the voluntary hospitals, this resistance was slowly weakening, no doubt motivated by the parlous financial condition of the voluntary hospital system. Local authority interests would also be better served by more centralised planning; since they were dependent on income from rates, such authorities could not always guarantee the provision of services. Though these groups were of course protecting their own interest, the government's proposals were - certainly in the early inter-war years - partly motivated by fear of working class demands for reform. Thus, though there were moves towards a state medical service, there remained considerable dispute as to the organisation of such a service. In the next section, therefore, the development of proposals for the post-war hospital service is examined in detail.

4.3 Wartime hospital policy

In order to clarify the major themes in hospital policy prior to the setting up of the NHS, this section considers two main issues. Firstly, the reasons why a qualitative extension of state intervention became necessary are examined (section 4.3.1) and secondly, the debates on the form of the future hospital service are summarised. Reliance is placed largely upon contemporary state papers in order to illustrate how these issues were addressed, debated and resolved.
4.3.1 The necessity for increased state intervention in health care and hospital planning.

In accounting for the emergence of a consensus on the necessity for an increase in state involvement in the provision of hospital facilities, three factors are important. These concern the problems of the voluntary and municipal hospital systems, the success of the centrally-organised Emergency Medical Service (EMS) hospitals, and - more generally - an awareness that state involvement in welfare delivery would be essential both in terms of providing services which could not otherwise be guaranteed under existing social arrangements, and also in terms of conceding to likely working-class pressure after the war.

No real national hospital system could be said to exist prior to World War 2, and three main policy objectives were identified. These were to make good the overall bed shortage; to iron out the inequalities resulting from the ill-balanced and uncoordinated development of services; and to ensure the efficient use of the service. The second of these was perhaps the most important, and it was recognised that placing a duty on local authorities to provide services would not necessarily solve the problem, since provision would be dependent on rate income and local political influences (4.1). In addition, the voluntary hospitals were in a serious financial condition and they had not adapted to changed circumstances following the 1929 Local Government Act which had empowered local authorities to provide acute hospital services (4.2). Coordination with other hospitals was rare, and it was claimed that the voluntary hospitals had been complacent, ignored
warnings as to their future, and rested on their laurels (4.3). It was also probable that the voluntary hospitals would become completely impoverished after the war; they would have to cope with increased demand from returning military casualties, and considerable capital development would be essential, to make good the bomb damage suffered by many urban hospitals (4.4). If this source of hospital care was not to disappear, a rather greater degree of state support would be required.

Secondly, the success of the EMS hospital scheme prompted consideration of the possibility that centralised control of hospital development would also be desirable in peacetime. The EMS scheme had been set up in 1938 and - under the Civil Defence Act, 1939 - the Ministry of Health became responsible for treating air raid casualties. A regional organisation of hospital services was set up to discharge this responsibility and 1,000 new operating theatres had been provided by the outbreak of war (Allen, 1979, 21); by late 1941, an additional 80,000 beds had been made available (4.5). In what was to become the Newcastle RHB area, 11 EMS hospitals (or major extensions of existing facilities) provided 3,719 additional beds (see section 4.4 below). These additional resources would be a 'powerful weapon' for any government wishing to extend state control of hospitals, since they would have 'something to offer' local authorities who might otherwise merely defend their own vested interests (4.6). The EMS scheme was so successful that full state control was seen as desirable in peacetime (4.7) and it was also instrumental in educating those running the voluntary hospitals to accept a coordinated service (4.8). Hence it was both necessary and appropriate that a full state hospital service should be
considered, though there was to be considerable dispute over the form of the service.

While the need for more coordinated planning was evident from the condition of the existing hospital system, and the potential for such planning had been clearly demonstrated, possibly the most important direct pressure on the state was the need to accede to working class pressure for reform. An extension of welfare services was therefore a matter of 'immediate practical concern' (Doyal, 1979, 177) - a point explicitly recognised early in the war by senior civil servants in the Ministry of Health (4.9). Though the war had diverted attention from potentially dangerous political issues towards the national concern for the defeat of Germany, this was not sufficient to legitimate the wartime hardships undergone by the majority of the population. To ensure continued political stability, therefore, a 'new and better Britain' had to be promised (Forsyth, 1966, 21; Navarro, 1978, 30). It is against this background that the emergence of proposals for a national hospital service (4.10) and of the social security measures (including a comprehensive health service) of the Beveridge Report (Beveridge, 1942) should be interpreted. While there were important pressures for social reform to which the state responded by promising an extension of welfare services, the changes that took place were to be set squarely within limits prescribed by the existing social order (Kincaid, 1973, 48; Navarro, 1978, 31). Space prevents fuller consideration of the setting up of the NHS (see Eckstein, 1959; Navarro, 1978; Pater, 1981); instead, attention is now focused on the development of proposals for the future hospital service.
4.3.2. **The evolution of hospital policy during the war.**

This section concentrates on two themes: the form of the organisation of the hospital service, and the extent to which state control was to be imposed.

Several inter-war reports (see section 4.2) had advocated a regional organisation for hospital services for various reasons. Firstly, a regional coordinating mechanism was required, to prevent overlapping of services and competitive building, secure treatment at 'key' (4.11) hospitals for patients resident in areas which did not already possess such services, and to ensure liaison between hospitals and hospital authorities on staff appointments (4.12). Secondly, a regional organisation was essential if a realistic attempt was to be made to provide all forms of medical care in all areas of the country. In some ways this was a simple matter of threshold populations for service provision; regional units were the 'proper' scale for hospital administration, since they 'embrace all kinds of hospital facilities', whereas not all counties or county boroughs could form a separate unit, and to provide the necessary services in each county or county borough would be extravagant (4.13). Moreover, given the increased scope and specialised character of hospital care, a regional organisation was also required in the interests of economy (4.14).

Having established the necessity for a regional organisation, what factors would determine its size and what would be the future pattern of services within it? Regional units were seen as essential, but there were likely to be practical problems in securing a public interest in the running of the service; furthermore, virtually any size of region would be inappropriate from the point of view of provision of some
local services (4.15). However, since wartime proposals for hospital provision generally envisaged a coordination of existing arrangements - as opposed to greater unification or integration of voluntary and municipal hospitals - then in the interests of administrative efficiency, it was desirable that as few units as possible were involved. Wartime plans therefore advocated a small number of regional units, each of which would preferably be based on a teaching hospital. Within these, a network of 'base' hospitals of 1,000 - 2,000 beds was envisaged, providing a range of acute surgical and consultative outpatient facilities. This network would be complemented by a series of specialist units supplying less frequently needed facilities, and the cottage hospital system was worthy of retention in rural areas (4.16). Thus the early wartime proposals concurred on the need for rationalisation and proposed that the future hospital services would be based on the (somewhat crude) hierarchical system outlined above. However, this issue was considerably less contentious than the complicated negotiations concerning the extent of state control and the arrangements for regional planning and administration.

Although the necessity for increased state involvement was generally agreed, there was considerable reluctance to challenge the voluntary hospitals and the medical profession - the two bodies seen as most entrenched in their opposition to such a development. Complete state control was seen almost as a revolutionary step; an early wartime document compared this to the suppression of the monasteries by Henry VIII (4.17). Even a major extension of state involvement would provoke 'ferocious' professional opposition; the medical profession were thought likely to argue that advantage had been taken of
the war to 'betray' them and impose a full state medical service (4.18). Consequently, early wartime proposals insisted that coexistence and cooperation of municipal and voluntary hospitals were both possible and desirable. The interests of the latter, in particular, were strongly defended; the Nuffield Provincial Hospitals Trust argued forcefully for retention of voluntary hospitals on the grounds of the contribution these could make to the reduction of government expenditure on hospitals (4.19). The Coalition government's first wartime proposals went no further than advocating coordination (4.20). This was attacked by local authority spokesmen as being simply an attempt to prop up the voluntary hospital system (4.21) - a view supported by the apparent unwillingness of senior civil servants to challenge this system (4.22).

Subsequent proposals (Ministry of Health, 1944) reproduced the above view, arguing that the voluntary hospitals would cooperate with the municipal hospitals on an independent contractor basis. However, as Aneurin Bevan (4.23) was to observe, this scheme 'ran away from so many vested interests that in the end...(there was) no scheme at all' (quoted in Foot, 1973, 130). This resulted from the proposed structure of the service. Ad hoc regional bodies were proposed, appointed centrally by the Minister of Health, yet the voluntary hospitals were to be permitted to choose whether or not they joined the service. This scheme failed to satisfy the medical profession, who felt that the regional body should have rather more responsibility for planning (4.24) the local authorities, from whom the scheme removed a great deal of responsibility, (Navarro, 1978, 35), and the voluntary hospitals, whose view was that since municipal hospitals were still directly
controlled by the regional authorities, these hospitals would be given priority in development (4.25). In these terms the proposals of the Coalition government were an attempt to rationalise the existing pattern of service provision without threatening the interests of those in control of the hospitals.

However, the Labour government elected in 1945 had, in principle, a clear mandate to challenge the existing control and ownership of the hospital service; full state ownership and control was proposed. Yet this proposal met considerable resistance (as indeed did Labour's plans for a national health service - see Navarro (1978), Abel-Smith (1964), Foot (1973), Eckstein (1959)).

As Minister of Health, Bevan (see note 4.23) advocated full state ownership of hospitals for several reasons. It would secure unified control and facilitate planning; ensure public control of public expenditure; permit the organisation of hospital services on 'natural' areas unhandicapped by local authority boundaries; avoid a separation of hospital planning from the execution of plans; and it was likely to gain the support of the medical profession, 'who are, above all things, terrified of local authority control' (4.26). Bevan's proposals therefore envisaged state control of all hospital services, though the teaching hospitals were to be run by separate organisations (see Appendix 1). Administration was to be placed in the hands of regional boards, though Bevan hoped that a future local government reorganisation would enable the closer integration of hospital and local government services (see Foot, 1973, 1973, 263-264). Regional Boards would operate under the 'general direction' of the Minister but
'the aim would be the maximum degree of decentralisation in the administration'. Below the RHBs, day-to-day operation of the service would be entrusted to district committees. Though financed by central government, the service was to be operated in such a way as to ensure a 'free and flexible degree of decentralised control'. The reasons for these proposals, and the opposition to them, are now considered (4.27).

Full state control was advocated because the voluntary hospital system was 'an anachronism'; it had failed to provide a good service and many hospitals were on the point of bankruptcy (4.28). Financial support for voluntary hospitals had fallen to such an extent that the state would have to guarantee 70-90% of their income, and contributions on such a scale were inconceivable without an extension of state control. Furthermore, only through full state control would it be possible to plan the service in such a way as to eliminate inequalities in provision, thereby carrying out the government's pledge to provide a comprehensive national service (4.29).

As to the precise form of state control, a local government system could not guarantee the elimination of the existing inequalities, due to the problems inherent in financing a service from the rates. In addition, larger units than individual local authorities were seen as essential, and the extent to which local authorities had provided hospitals in the past had varied both geographically and qualitatively. Alternatives to a regional organisation - such as a new, directly elected authority - were administratively complex and remote from public control (4.30).

These plans were vigorously opposed by local government spokesmen; for example, Herbert Morrison (4.31) feared damage
to the fabric of local government, and was also concerned at the centralisation and rigidity of the proposals (4.32). However, Bevan countered such objections on the grounds that a less radical scheme would neither solve the financial and administrative problems of the existing system, nor would it eliminate inequalities in service provision. Moreover, the proposals were by no means as rigid as their opponents feared; Bevan's plans saw local RHBs and committees as:

'agents... of my department... (with) substantial executive powers, subject to a broad financial control' (4.33)

What was involved, then, was not so much an attack on the functions of local government but rather their 'proper rationalisation' (4.34).

As regards the medical profession, relatively little opposition developed to what was termed 'the largest seizure of property since Henry VIII confiscated the monasteries' (4.35). The most plausible interpretation of this seems to lie in the generous concessions made to the medical profession at the setting up of the NHS; in particular, the separation of teaching hospitals from the rest of the NHS allowed it to retain a substantial degree of control over medical education, thus according it a privileged status in terms of its ability to define the nature of health care (4.36). The effect of this and of other concessions, such as generous representation on RHBs (Guillebaud Committee, 1956, 96-98; see also Crossman, 1972) and permitting private practice in NHS hospitals, was that while the state was responsible for financing and planning service delivery, what was being delivered was largely in the control of the medical profession (see Crossman, 1972;
Thus the NHS represented an extension of state control in the interests of guaranteeing the provision of a service which could not effectively be provided and planned by private bodies or local authorities. The 1945-1951 Labour government saw state intervention in the economy as a means of increasing the efficiency of the economy as a whole, rather than using such intervention to effect a shift in class power in society (Coates, 1975, 47-54; Hudson, 1981, 473-477; Miliband, 1973, 272-294). This does not appear inconsistent with arguments which stress that the organisation of the working class, politically and ideologically, was insufficiently strong effectively to challenge existing social relations (Doyal, 1979, 179; Corrigan, 1977, 91) though there was considerable pressure to improve working class living conditions (e.g. via extended welfare services) within that framework.

To summarise, while there was substantial agreement on the form to be taken by the postwar hospital service, its organisation and control were contentious issues. In particular, state control of hospital provision was strongly resisted at first, though subsequently accepted subject to concessions on the structure and control of the NHS. The theoretical implications of this will be considered below (section 4.5) following a summary of the problems to be faced by postwar planning.

4.4 The condition of the hospital stock in the Newcastle RHB area.

Drawing upon the evidence and recommendations of the wartime Hospital Surveys (Ministry of Health, 1946, volumes 9 and 10),
this section illustrates the problems to be tackled by postwar planning. Some general remarks concerning the national situation are followed by evidence concerning the condition of the hospital stock in what was to become the Newcastle RHB. The Hospital Survey's preliminary ideas on postwar planning are also noted.

While the voluntary hospital system was conventionally identified with the best traditions of medical practice in Britain, and in particular with high quality care available in teaching hospitals, in fact only 30 voluntary teaching units existed in total, and their standards of care were not always found in the rest of the voluntary sector. Moreover, the small size of such units (other than the teaching hospitals)-especially rural cottage hospitals and specialist units for specific diseases - had rendered them increasingly uneconomic and difficult to staff. Likewise, the municipal hospitals had developed in an uncoordinated fashion; in many large towns there existed competing voluntary and municipal facilities, the latter having been called into existence to cover gaps left by the voluntary system. In addition, the statutory duty imposed on local authorities to provide hospitals for particular categories of disease, had produced a tendency for the treatment of these types of illness to become separated from the general stream of medical care (Nuffield Provincial Hospitals Trust, 1946). Finally, the EMS hospitals had provided a considerable addition to the acute hospital stock, though these facilities were often somewhat isolated in order to minimise the risks of air-raid damage (see Dunn, 1952, for an account of the EMS scheme).

The problems of organisation and coordination of these different sources of hospital care were compounded by
disparities in bed provision between voluntary and municipal hospitals, and between geographical areas. Firstly, there were differences between voluntary and municipal hospitals in terms both of hospital size (table 4.1) and function (table 4.2). The former was partly a result of the different financial bases of voluntary and municipal hospitals, voluntary facilities being dependent largely on individual generosity and/or public subscription. By contrast, the more secure financial situation of local authority hospitals (vis-a-vis voluntary hospitals) in the inter-war years, had permitted the financing of larger-scale developments. This is only a partial account, however, because it ignores the obligation on local authorities to provide facilities for the care of the chronic sick and the isolation of those suffering from infectious disease. Such units were, in general, considerably larger than the specialist acute hospitals; hence disparities in function and size of voluntary and municipal hospitals were closely interlinked (table 4.2).

Geographical inequalities in service distribution were evident at both regional (table 4.3) and sub-regional (table 4.4) scales. Note, in the former case, the below-average provision in South Wales, the East Midlands and the North East, both overall and for general acute services, by comparison with the relatively high levels of bed availability in the Berkshire, Buckinghamshire and Oxford regions, as well as in the North West and Yorkshire. Considerable work remains to be done to account for these differentials. Clearly, the effect of socio-economic conditions in different areas on contributions to voluntary hospitals would be crucial. Thus the Palmer Memorial
Table 4.1 Size distribution of hospitals in England and Wales, 1938\(^{(1)}\)

<table>
<thead>
<tr>
<th>Number of Beds</th>
<th>Type of hospital</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Voluntary</td>
<td>Municipal</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number</td>
<td>Per Cent</td>
<td>Number</td>
</tr>
<tr>
<td>30</td>
<td>345</td>
<td>33</td>
<td>96</td>
</tr>
<tr>
<td>30-100</td>
<td>434</td>
<td>41</td>
<td>99</td>
</tr>
<tr>
<td>100-500</td>
<td>256</td>
<td>24</td>
<td>159</td>
</tr>
<tr>
<td>500</td>
<td>19</td>
<td>2</td>
<td>71</td>
</tr>
<tr>
<td>Total</td>
<td>1054</td>
<td>100</td>
<td>425</td>
</tr>
</tbody>
</table>

Source: Summary Statistics from the Hospital Surveys - held in PRO MH 80/34

Notes
1. This is clearly only a sample of hospital accommodation, since at the inception of the NHS over 3,000 hospitals were taken over. However the basis of the sample, and its spatial coverage, were not given.
Table 4.2 Functions of non-psychiatric voluntary and municipal hospitals in England and Wales

<table>
<thead>
<tr>
<th>Speciality</th>
<th>Type of hospital</th>
<th>Voluntary</th>
<th>Municipal</th>
<th>Total (2)</th>
<th>Total Available (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hospitals Beds</td>
<td>Hospitals Beds</td>
<td></td>
<td>Hospitals Beds</td>
<td></td>
</tr>
<tr>
<td>General acute</td>
<td>711 60198</td>
<td>162 69135</td>
<td>873</td>
<td>129331</td>
<td>141721</td>
</tr>
<tr>
<td>Special</td>
<td>196 16105</td>
<td>31 8543</td>
<td>227</td>
<td>24648</td>
<td>26956</td>
</tr>
<tr>
<td>Chronic</td>
<td>27 1730</td>
<td>377 49199</td>
<td>404</td>
<td>49929</td>
<td>59211</td>
</tr>
<tr>
<td>TB</td>
<td>66 7330</td>
<td>134 14389</td>
<td>200</td>
<td>21719</td>
<td>27402</td>
</tr>
<tr>
<td>Maternity</td>
<td>54 1819</td>
<td>98 2034</td>
<td>152</td>
<td>3853</td>
<td>4039</td>
</tr>
<tr>
<td>Isolation</td>
<td>3 297</td>
<td>636 42725</td>
<td>639</td>
<td>43022</td>
<td>43665</td>
</tr>
<tr>
<td>Totals</td>
<td>1057 87479</td>
<td>1438 186025</td>
<td>2495</td>
<td>273502</td>
<td>302994</td>
</tr>
</tbody>
</table>

Source: Statistics held in PRO MH 80/34

Notes
1. Data refer to 1938 apart from those for total available beds, which are net figures for an unspecified date towards the end of the war - see also note 3.

2. Since the NHS initially involved state control of over 3000 hospitals, these figures are evidently incomplete. However, the basis on which they were gathered was not given.

3. These figures comprise the total beds available in 1938, plus beds provided in EMS units, minus beds lost through wartime damage. The net gain in beds was therefore approximately 30,000. Though the exact date at which these statistics were gathered was not given, from the dates on other papers in this file it seems reasonable to infer that the data refer to late 1944 or early 1945.
### Table 4.3  Geographical variations in availability of types of bed per 1000 population

<table>
<thead>
<tr>
<th>Survey Area</th>
<th>General Acute</th>
<th>Chronic Sick</th>
<th>Maternity</th>
<th>TB</th>
<th>Infectious Diseases</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>London</td>
<td>3.6</td>
<td>1.3</td>
<td>0.32</td>
<td>0.62</td>
<td>1.1</td>
<td>6.94</td>
</tr>
<tr>
<td>North West</td>
<td>4.3</td>
<td>1.25</td>
<td>0.09</td>
<td>0.73</td>
<td>0.9</td>
<td>7.27</td>
</tr>
<tr>
<td>North East</td>
<td>3.0</td>
<td>1.1</td>
<td>0.10</td>
<td>0.74</td>
<td>1.4</td>
<td>6.34</td>
</tr>
<tr>
<td>Yorkshire</td>
<td>3.3</td>
<td>1.6</td>
<td>0.17</td>
<td>0.76</td>
<td>1.2</td>
<td>7.03</td>
</tr>
<tr>
<td>Eastern</td>
<td>2.5</td>
<td>2.7</td>
<td>0.001</td>
<td>0.90</td>
<td>0.8</td>
<td>6.90</td>
</tr>
<tr>
<td>West</td>
<td>3.8</td>
<td>1.8</td>
<td>0.09</td>
<td>0.5</td>
<td>0.8</td>
<td>6.99</td>
</tr>
<tr>
<td>Midlands</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>East</td>
<td>3.0</td>
<td>1.1</td>
<td>0.1</td>
<td>0.3</td>
<td>1.0</td>
<td>5.5</td>
</tr>
<tr>
<td>Berks, Bucks, Oxon.</td>
<td>4.7</td>
<td>1.8</td>
<td>0.09</td>
<td>0.7</td>
<td>0.9</td>
<td>6.89</td>
</tr>
<tr>
<td>South Western</td>
<td>3.4</td>
<td>1.8</td>
<td>0.09</td>
<td>0.7</td>
<td>0.9</td>
<td>6.89</td>
</tr>
<tr>
<td>South Wales</td>
<td>2.16</td>
<td>1.11</td>
<td>0.18</td>
<td>0.76</td>
<td>0.6</td>
<td>4.81</td>
</tr>
</tbody>
</table>

Source: Statistics held in PRO MH 80/34

Notes

1. Date to which data refer was not given; however, since the spatial units seem to correspond to the areas covered by the ten volumes of the Hospital Surveys (Ministry of Health, 1946, volumes 1-10) it seems reasonable to put this at 1945-1946.

2. These units were not defined but their titles correspond exactly to those of the ten volumes of the Hospital Surveys.
Table 4.4  Local variations in bed availability per 1000 population (1)

<table>
<thead>
<tr>
<th>Area (2)</th>
<th>General Acute</th>
<th>Chronic Sick</th>
<th>Maternity</th>
<th>TB</th>
<th>Infectious Disease</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>County of London</td>
<td>6.3</td>
<td>1.2</td>
<td>0.41</td>
<td>0.71</td>
<td>1.6</td>
<td>10.22</td>
</tr>
<tr>
<td>Leeds Area</td>
<td>2.9</td>
<td>0.5</td>
<td>0.28</td>
<td>0.8</td>
<td>1.1</td>
<td>6.58</td>
</tr>
<tr>
<td>Rhondda Valley</td>
<td>2.6</td>
<td>2.0</td>
<td>-</td>
<td>-</td>
<td>0.7</td>
<td>5.3</td>
</tr>
<tr>
<td>Bath</td>
<td>4.1</td>
<td>2.4</td>
<td>0.38</td>
<td>0.27</td>
<td>1.0</td>
<td>8.15</td>
</tr>
<tr>
<td>Wiltshire</td>
<td>2.2</td>
<td>1.6</td>
<td>0.22</td>
<td>0.6</td>
<td>0.9</td>
<td>5.52</td>
</tr>
</tbody>
</table>

Source: Statistics held in PRO MH 80/34

Notes
1. Date not given but data accompanied those summarised in table 4.3; it seems likely therefore, that they refer to the same date.
2. Spatial units were not defined.
Hospital, in Jarrow, had (in financial terms) 'fallen on evil
days' (Ministry of Health, 1946 (volume 10), 44) following
the closure of Palmer's Shipyard in 1934. Indeed, according
to the Hospital Surveyors:

'no inquiry about Tyneside can disregard the
fact that it was a distressed area between the
wars, and this has undoubtedly affected the
development of the hospital service'.
(Ministry of Health, 1946 (volume 10), 35)

Within the Newcastle RHB area, particular concern was
expressed at the relative underprovision and/or poor quality
of hospital services in the west Cumberland, central and south-
west Durham, and south east Northumberland areas (Ministry
of Health, 1946 (volume 9), 112-116; (volume 10) 52, 88-89,
96, 98 – see also figure 4.1). More detailed interpretation
of these differentials would however, be unjustified in the
absence of comprehensive evidence on the development of
hospitals in specific circumstances.

As well as these distributional inequalities, an overall
deficiency in bed provision had been identified, and it was
estimated that an additional 98,000 beds were required (Nuffield
Provincial Hospitals Trust, 1946). However, the surveyors were
by no means confident that such problems would be eliminated
by new provision, for 'it is the common experience... that
new provision only serves to reveal a considerable hidden need'
(Ministry of Health, 1946, (volume 10), 12; compare Haynes and
Bentham, 1979). On a more local scale, the historical develop-
ment of many hospitals on restricted urban sites had led to
overcrowding and hence to difficult working conditions (Ministry
of Health, 1946 (volume 9), 17; (volume 10), 37, 39, 41, 55,
68, 71, 83, 91).

Such problems were compounded by shortages of, and
Figure 4.1: Location of hospitals in the Newcastle RHB area, 1943
(see overleaf for inset)
Inset to figure 4.1 (see previous page)
inequalities in the distribution of, consultant staff. These were concentrated in Newcastle upon Tyne (table 4.5), because consultants offered their services to voluntary hospitals on an unpaid basis and so these staff would only settle where there was sufficient private practice to guarantee them a regular income. This had serious implications for the treatment of patients in peripheral hospitals, which was either carried out by GPs or delayed until an appropriately qualified consultant visited a private patient (Nuffield Provincial Hospitals Trust, 1946). Finally, in a further reference to the implications of socio-economic conditions in the region for hospital development, the Hospital Survey questioned whether there was enough demand for (or ability to pay for) private practice to support a large addition to the number of consultants (Ministry of Health, 1946 (volume 10), 13). This point was raised because, at the time the Survey was conducted (i.e. during the war) there had been no concrete proposals for full state control of health services; if future developments were dependent on an expansion in private practice, then, it was unlikely that much would be achieved in the North East.

Furthermore, the physical condition of the hospital stock left much to be desired; buildings were small, out of date, and accommodation was inconvenient and cramped (Ministry of Health, 1946 (volume 10), 13). Compounded by the lack of coordination between voluntary and municipal hospitals, and by the overdevelopment of particular specialities (4.37), such problems would require an immense programme of capital investment (Ministry of Health, 1946 (volume 9), 17-18). Tables 4.6 (number of hospitals and types of available beds) and 4.7 (size distribution of hospitals) provide summary statistics...
Table 4.5  Distribution of consultant medical staff in general and special hospitals in the Newcastle RHB area, 1943.

<table>
<thead>
<tr>
<th>Area</th>
<th>Number of Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northumberland</td>
<td>8</td>
</tr>
<tr>
<td>Newcastle upon Tyne C.B.</td>
<td>63</td>
</tr>
<tr>
<td>Tynemouth C.B.</td>
<td>7</td>
</tr>
<tr>
<td>Durham</td>
<td>17</td>
</tr>
<tr>
<td>Darlington C.B.</td>
<td>6</td>
</tr>
<tr>
<td>Gateshead C.B.</td>
<td>2</td>
</tr>
<tr>
<td>South Shields C.B.</td>
<td>6</td>
</tr>
<tr>
<td>Sunderland C.B.</td>
<td>23</td>
</tr>
<tr>
<td>West Hartlepool C.B.</td>
<td>2</td>
</tr>
<tr>
<td>Yorks (N.Riding)</td>
<td>0</td>
</tr>
<tr>
<td>Middlesbrough C.B.</td>
<td>11</td>
</tr>
<tr>
<td>Cumberland</td>
<td>4</td>
</tr>
<tr>
<td>Carlisle</td>
<td>7</td>
</tr>
<tr>
<td>Westmorland</td>
<td>4</td>
</tr>
</tbody>
</table>

Source: Ministry of Health, 1946, volumes 9 and 10.
on hospital provision in the Newcastle RHB area, and the facilities available are mapped (figure 4.1). Local authority facilities, in general, were considerably larger than the voluntary hospitals; municipal general hospitals (average size 445 beds) were five times as large as their voluntary counterparts (average size 88 beds). The preponderance of small hospitals posed serious problems; many of these were obsolete and/or inefficient (Ministry of Health, 1946 (volume 9), 22, 112, 113; (volume 10), 40, 41, 49, 51, 55, 71, 79, 92), and their physical condition had, in several cases, degenerated to the point where they were unsuitable for continued use (Ministry of Health, 1946 (volume 9), 112; (volume 10), 13, 40, 42, 44, 47, 48, 54, 70, 81, 91). Considerable rationalisation and reorganisation of services would also be a necessary corollary of the uneven and uncoordinated development of acute hospital services in small or medium sized units (Ministry of Health, 1946 (volume 10), 51-52, 61-65, 72, 92). As regards the emergency hospitals, these had provided an additional 3719 beds (table 4.8) either at entirely new sites (Durham, Hexham) by extensions to existing facilities (Bishop Auckland, Chester-le-Street) or taking over accommodation at mental institutions (Shotley Bridge, Ryhope). However these were, in several cases (Sedgefield, Stannington, Hemlington) located at some distance from major centres of population, and so were not ideal from the point of view of postwar planning (figure 4.1). In the light of these problems, how did the Hospital Surveyors see the postwar hospital service developing?

Firstly, the development of the region's hospital services was to focus on the teaching hospital complex in Newcastle upon Tyne, in line with central government policy that each RHB should be closely linked to a teaching hospital.
### Table 4.6 Number of hospitals and types of beds in the Newcastle RHB area\(^1\), 1943.

<table>
<thead>
<tr>
<th>Type of hospital</th>
<th>Number of Hospitals</th>
<th>Voluntary</th>
<th>Municipal</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Acute</td>
<td>64</td>
<td>3094</td>
<td>2923</td>
<td>6017</td>
</tr>
<tr>
<td>Specialist Acute</td>
<td>127</td>
<td>516</td>
<td>409</td>
<td>925</td>
</tr>
<tr>
<td>Maternity</td>
<td>364</td>
<td>171</td>
<td>3750</td>
<td>535</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>1925</td>
<td>525</td>
<td>2450</td>
<td></td>
</tr>
<tr>
<td>Chronic Sick</td>
<td>1930</td>
<td>43</td>
<td>1973</td>
<td></td>
</tr>
<tr>
<td>Infectious Disease</td>
<td></td>
<td>-</td>
<td>3750</td>
<td>3750</td>
</tr>
<tr>
<td>Sick Staff</td>
<td>17</td>
<td>13</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Pay Beds</td>
<td>3</td>
<td>245</td>
<td>248</td>
<td></td>
</tr>
<tr>
<td>Beds in EMS Huts</td>
<td>1300</td>
<td>260</td>
<td>1560</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>12621</td>
<td>4867</td>
<td>17488</td>
<td></td>
</tr>
</tbody>
</table>

**Source:** Ministry of Health, 1946, volumes 9, 10.

**Notes**

1. Statistics here refer to hospitals in the area for which Newcastle RHB took responsibility from July 1948; they therefore include data for the Teaching Hospitals in Newcastle upon Tyne.

2. This refers to facilities provided under the aegis of the Emergency Medical Service; the data is not strictly comparable with that of table 4.8 since it refers only to beds added to existing facilities. It does not, therefore, include Emergency Hospitals erected on new sites.
### Table 4.7 Distribution of hospitals in the Newcastle RHB area by size and type, 1943.

<table>
<thead>
<tr>
<th>Size (Beds)</th>
<th>Type of hospital (1)</th>
<th></th>
<th></th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>General Acute</td>
<td>Specialist Acute</td>
<td>Chronic</td>
<td>Infectious Disease</td>
<td></td>
</tr>
<tr>
<td>50</td>
<td>28</td>
<td>26</td>
<td>14</td>
<td>51</td>
<td>119</td>
</tr>
<tr>
<td>51-100</td>
<td>7</td>
<td>7</td>
<td>5</td>
<td>12</td>
<td>31</td>
</tr>
<tr>
<td>101-200</td>
<td>10</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>25</td>
</tr>
<tr>
<td>201-300</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>300</td>
<td>11</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>56</td>
<td>39</td>
<td>25</td>
<td>71</td>
<td>191</td>
</tr>
</tbody>
</table>

Source: Ministry of Health, 1946, volumes 9 and 10.

Note: The classification of type of hospital employed here is that used by the Hospital Surveyors (Ministry of Health 1946, volumes 9 and 10).
Table 4.8 Additions to hospital capacity under the EMS scheme in the Newcastle RHB area

<table>
<thead>
<tr>
<th>Location</th>
<th>Number of Beds</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shotley Bridge</td>
<td>879</td>
<td>Former mental colony taken over by the EMS</td>
</tr>
<tr>
<td>Northallerton</td>
<td>416</td>
<td>EMS hospital</td>
</tr>
<tr>
<td>Durham (Dryburn)</td>
<td>390</td>
<td>EMS hospital</td>
</tr>
<tr>
<td>Hexham</td>
<td>390</td>
<td>EMS hospital</td>
</tr>
<tr>
<td>Sedgefield</td>
<td>330</td>
<td>EMS hospital</td>
</tr>
<tr>
<td>Ryhope</td>
<td>300</td>
<td>EMS hospital</td>
</tr>
<tr>
<td>Hemlington (Middlesbrough)</td>
<td>260</td>
<td>EMS addition to Smallpox Hospital</td>
</tr>
<tr>
<td>Stannington</td>
<td>260</td>
<td>EMS hospital</td>
</tr>
<tr>
<td>Bishop Auckland</td>
<td>234</td>
<td>EMS addition to PAI (1)</td>
</tr>
<tr>
<td>Chester-le-Street</td>
<td>156</td>
<td>EMS addition to PAI</td>
</tr>
<tr>
<td>Carlisle (Cumberland Infirmary)</td>
<td>104</td>
<td>EMS addition to existing hospital</td>
</tr>
<tr>
<td>Total</td>
<td>3719</td>
<td></td>
</tr>
</tbody>
</table>

Source: Ministry of Health, 1946 (volumes 9 and 10).

Note
1. PAI - Public Assistance Institution
Before the war, various proposals had been put forward for a Hospital Centre in the city; several of the smaller specialist units in Newcastle had sought sites within the curtilage of the RVI (4.38). The concept of a Hospital Centre was taken up by the Survey; Newcastle was already:

'the centre of medicine in the North East... it should take an even higher place as a medical centre than it has in the past'.

(Ministry of Health, 1946 (volume 10), 14).

Subsequent proposals for the development of this medical complex were, however, to provoke controversial debates in the 1960s (see chapters 8-10 below).

Secondly, the Survey made recommendations which, in arguing for district hospitals of 600-800 beds, (Ministry of Health, 1962 (volume 10), 14) clearly anticipated the DGH concept of the 1962 Hospital Plan (Ministry of Health, 1962, 6). Two such facilities - the RVI and the General Hospital - would be provided in Newcastle; in Sunderland, Durham and Middlesbrough the district hospital service would be provided by coordination of existing facilities; while in such centres as Carlisle and Darlington one major hospital would be developed (Ministry of Health, 1946 (volume 9), 114-116; (volume 10), 14-15, 96-99). Finally, the Survey recommended the retention of many rural cottage hospitals and the closure of a variety of small, inefficient and/or obsolete units, particularly isolation hospitals (Ministry of Health, 1946 (volume 10), 15-16, 22-28). The extent to which these proposals were realised, and the problems of postwar planning, are discussed in the following chapters.
4.5 Summary

The aim of this chapter has been to sketch the historical background to the material to be presented below (chapters 5-10). Hence section 4.2 outlined major issues in the development of the British hospital system, while section 4.4 illustrated some of the planning problems to which this had led. Section 4.3 is also central to this thesis insofar as it showed, firstly, that concepts such as regional planning of hospital facilities, and antecedents of the DGH concept (see chapter 6) had been the subject of public debate for many years; and secondly, that though there was some consensus both on these matters and on the need for greater state intervention in health service and hospital provision, there were considerable disputes over the form to be taken by the postwar hospital service. These disputes, in turn, have to be set against the background of broader social changes in wartime and postwar Britain if an adequate account is to be presented of the form to be taken by the NHS.

In terms of the theoretical implications of the foregoing, the changes in the nature and extent of state intervention in health care delivery seem to provide support for Offe's views on the qualitatively-changing character of the capitalist state. Broadly speaking this involves a change from an allocative mode - the state or its agents are involved in setting minimum public health standards, for instance - to a productive mode of intervention, in which the state intervenes more directly in the production of health service goods and manpower. However, such changes cannot simply be read off from - say - a periodisation of stages of capitalist economic development, nor are they a consequence of the internal logic of the laws
of motion of capitalism. Rather, such changes are fiercely contested - witness the reluctance on the part of the British state to take full control of hospital services - and they do not always and inevitably operate in the interests of capital and/or the capitalist class. For instance, in setting up the NHS, the state intervened against the voluntary hospitals but did not radically reorganise the way health care was produced and delivered; in this sense the NHS represented less of a revolutionary step than a rationalisation of existing arrangements. In this sense the development of the NHS was characterised by what Offe (1974) would term a **structural** selection mechanism, whereby significant alterations in social relations are excluded from the range of possible policy options. This is important in considering what follows, particularly in terms of understanding the way in which health service planning issues are defined and debated, and in terms of understanding which groups are in a position to influence state policy formulation.
Footnotes

4.1 Ministry of Health Memorandum on The future development of the hospital service, 24.5.38 - held in PRO MH 80/24.

4.2 Ministry of Health Paper, The Voluntary Hospitals of Great Britain, 1920-1940, 15.5.40 - held in PRO MH 80/24.


4.4 Ministry of Health note on Suggestions for a Postwar Hospital Policy, August 1941 - held in PRO MH 80/24.

4.5 This figure was quoted in a Ministry of Health paper on The Emergency Hospital Scheme as a starting point for future development, 2.9.41 - held in PRO MH 77/25.

4.6 Ibid.

4.7 Notes on Postwar Policy, 8.5.40 - held in PRO MH 80/24.

4.8 Notes on Hospital Policy, 18.11.40 - held in PRO MH 80/24.

4.9 Noted in a Ministry of Health paper on Suggestions for a Postwar Hospital Policy, August 1941 - held in PRO MH 80/24.

4.10. These proposals (announced in the House of Commons, 9.10.41) would have imposed a duty on local authorities to provide hospitals and set up a regional organisation for hospital services. Details of the scheme are given in a War Cabinet memorandum LP (41) 167, 14.10.41 - copy held in PRO MH 77/25.

4.11. It is clear, from a reading of Ministry of Health Bill Papers for the wartime years, that concepts of 'key' and 'base' hospitals were the subject of intensive discussion, with a view to using a system of such units as a basis for postwar hospital planning; see also note 4.17.

4.12 Noted in a memorandum on Postwar Policy - Outline Proposals, June 1942 - held in PRO MH 77/26 (see also section 4.2).

4.13 Noted in a Ministry of Health paper, Suggestions for a Postwar Hospital Policy, August 1941; and in a minute on Hospital Policy and Regionalisation (n.d. - 1942?) - both held in PRO MH 77/25.

4.14 Memorandum by the Nuffield Provincial Hospitals Trust (1941) on A National Hospital Service - copy held in PRO MH 77/25.
On this, a minute on Hospital Policy and Regionalisation (n.d.-1942?) - held in PR MH 77/25 - noted that:

'in reference to regionalisation we all have in mind an organisation for a unit larger than a county or county borough, but a local representative organisation and not a localised piece of the central government...

... both a regional authority and an 'ad hoc' authority inevitably have difficulty in arousing popular interest, the one by virtue of its remoteness from the electors and the other by reason of the limitations of its functions. On the other hand, it is not likely that any single area of government can be found which will provide the most efficient unit for all purposes of government'.

(emphases added)

Ministry of Health note on Regionalisation, 18.8.42 - held in PRO MH 80/24.


Ibid. This memorandum also noted the arguments in favour of an extension of state control (the success of the EMS scheme, financial problems of the voluntary hospitals, etc.) and regarded such an extension as inevitable.

This point was made forcibly by the Nuffield Provincial Hospital Trust's (1941) Memorandum on the Coordination of Hospital Services - copy held in PRO MH 77/25 - which argued that:

'Financial and economic conditions in the postwar period will make it essential that the organisation of hospital services should be undertaken on lines which will ensure an efficient and adequate service with the minimum additional financial liability to public funds... it would (therefore) be undesirable to adopt a policy which would eliminate the voluntary hospital system or discourage the extension of voluntary schemes for the provision of financial support for hospital services'.

(emphases added)

Explained thus, in a Cabinet memorandum:

'(the) existing informal and unorganised partnership between local authorities and voluntary hospitals should continue, but put on a more regular footing so as to avoid the competitive building and overlapping that has occurred in the past'.

Extract from War Cabinet Memorandum LP (41) 167, 14.10.41 - copy held in PRO MH 77/25. The following extract from the Cabinet minutes expands on this:
4.20 (cont)

'The fundamental principle... was that of a partnership... but the voluntary hospitals were subordinated to the local authority in this sense, that it was the local authority that was made responsible for securing the provision of a public service adequate to the needs of the area. This would be effected by a scheme which would cover a wider area than that of an individual authority. For the first time the local authorities would have a duty, not merely a power, to provide hospitals'.

(emphases added)

Extract from the minutes of the Lord President's committee of the War Cabinet, LP (41) 48, 15.10.41 - held in PRO MH 80/34.

4.21 This view was articulated in an article entitled: 'Voluntary or municipal hospitals: the case for public control, published in The Star, 12.8.41, and written by Charles Latham (Leader of London County Council) - copy held in PRO MH 80/34.

4.22 For example a Ministry of Health memorandum, dated 9.2.41 - held in PRO MH 80/34-argued that the voluntary hospital system 'has its roots so deep in the national life that I should not expect its immediate breakup...' This view was by no means held unanimously within the Ministry, but it is clear from the above (and from other memoranda held in the same file) that proposals for postwar policy were (in the early wartime years at any rate) concerned largely with ensuring the coordination of voluntary and municipal hospitals.

4.23 Bevan was to be appointed Minister of Health in the 1945 Labour Government; for a detailed account of his role in the negotiations on the form of the NHS, see Foot (1973, 100-215).

4.24 This (regional organisation) was viewed by the BMA as being:

'the most important instrument in securing a good service and the essential protection of the profession against local authority control'.

Notes of a meeting between representatives of the BMA and the Minister of Health, 23.1.45 - held in PRO MH 80/34.

4.25 This reservation was expressed in a memorandum (n.d.-1944?) by the British Hospitals Association on the 1944 White Paper on a National Health Service - held in PRO MH 80/34.

4.26 These proposed advantages of a nationalised hospital service are summarised in a Secretary's minute on the Hospital Service, August 1945 - held in PRO MH 80/34.
The foregoing paragraph has summarised the arguments contained in Ibid.

PRO CAB 129/3, CP(45)205 - The Future of the Hospital Services.

Ibid.

Summarised from Ibid, in which the option of a new, directly elected authority was rejected on the grounds that not only was it remote from public control, but it would also generate an 'impossible hotch potch' of local government areas.

Lord President of the Council; former Leader of London County Council.

PRO CAB 129/3, CP (45) 227, 12.10.45.

PRO CAB 129/3, CP(45) 231, 16.10.45 - emphases added.

Ibid.


The teaching hospitals were claimed to be a special case:
'partly on the ground of their exceptional standing in the medical world, partly because it is a good thing to keep separate a field for innovation and independent experiment in method and organisation... partly because it is undesirable to introduce a full and direct state control into the Educational Field'.

PRO CAB 129/3 CP(45) 205. However, the separation of Teaching Hospitals (given their own separate Boards of Governors, responsible directly to the Minister of Health) from RHBs was to lead to problems of coordination - see Guillebaud Committee (1956, 75) and also chapter 10 (below).

Ministry of Health memorandum, - Reform of the Voluntary Hospital System, n.d. - probably early 1945 - held in PRO MH 80/34.

Tyne and Wear Archives Department, deposits 672/146 (Minutes of the Hospital Centre Committee, 1933-1945) and 672/151 (Board of Governors of the RVI - Reorganisation Committee minutes). These show that at various stages in the 1930s, small voluntary hospitals (the Princess Mary Maternity Hospital, Fleming Memorial Hospital) had all sought land within the RVI site. The principle of a unified Hospital Centre in Newcastle had been agreed by late 1942 (Hospital Centre Committee, 24.9.42 and 9.12.42).
5. **Postwar hospital policy and the development of the 1962 Hospital Plan.**

5.1 **Introduction**

Taking as its point of departure the evidence presented in the previous chapter concerning the problems to be resolved by postwar hospital planning, this chapter will discuss the extent to which these problems were resolved in the early postwar years. Section 5.2 therefore explores the problems posed for the Labour government up to 1951 by the perceived necessity to restrain expenditure, and section 5.3 then discusses the emergence of the 1962 Hospital Plan, accounting for this in terms of interrelated political and technical developments. Finally section 5.4 examines the consequences of these policies for hospital development in the Newcastle RHB.

5.2 **Public expenditure restraint and hospital planning: the Labour government 1948-1951.**

The inception of the NHS in 1948, and the consequent acceptance of state responsibility for the provision of a comprehensive health service, brought with it various problems for the Labour government. In particular the criteria upon which the service was to be run were by no means clear, reflecting - in general terms - the transition from production of health services for exchange to production for use; one implication of this is that it becomes extremely difficult to set operational goals for state activities (for a fuller account see Offe and Ronge, 1975). The rapidly increasing cost of the
NHS became a controversial issue within a short period of time, as it became evident that growing demand would necessitate the allocation of substantial additional resources to the NHS, thus contradicting the optimistic assertions of the Beveridge Report (Beveridge, 1942) that providing a free health service would actually reduce demand as the population became healthier. An increase in the resources allocated to the NHS was seen as potentially in conflict with broader macroeconomic strategy and so NHS finance began to make regular appearances on the Cabinet agenda. Bevan's first Cabinet memorandum on this topic noted three major problems to be faced by the NHS; the impossibility of satisfying the demand for its facilities, the possibility of abuse of the service, and its cost. Need for the service was enormous, not least because of the accumulated backlog from the war years, and costs could only be reduced if demand for services was to slacken off. However, the early indications were that rising costs were such that the estimates in force at the time were too low even to maintain the existing level of service provision. Additional finance was required unless beds were to be closed; further resources were essential if some of the 50,000 empty beds were to be re-opened; and the estimates would not be exceeded only if ad hoc cuts were made. For example the Liverpool and Manchester RHBs would both have had to close some 1,500 beds (5.1). The political consequences were potentially serious:

'it was unthinkable that a supplementary estimate should be avoided by closing down beds which were urgently required... (moreover) the imposition of a charge (for health service facilities) would greatly reduce the prestige of the NHS'.

(5.2)
Though he was sympathetic to such views, the Chancellor of the Exchequer had nevertheless - in his Budget speech - committed the government to the view that supplementary estimates could only be considered in special circumstances, such as major shifts in policy. Hence he could not accept the need for a supplementary estimate. The Cabinet therefore agreed that although services were not to be reduced, every effort should be made to restrict further increases in NHS costs (5.3).

However, these costs continued to give grounds for concern, and a memorandum by Herbert Morrison in late 1949 set out the problems, emphasising the severe constraints - both domestic and international - under which the government was operating (5.4). Despite the desirability of increased public expenditure, there was 'little margin for readjustments (in public expenditure policy)' if taxation was to be kept at a reasonable level. He therefore advocated much stricter economy, arguing for firmer controls on public expenditure and claiming that ministers should be:

'forced... to consider which of several desirable projects they will adopt within the limits of a specific sum devoted to the services for which they are responsible'. (5.5)

In effect Morrison was proposing control of expenditure in cash terms rather than by volume. Though there were counter-arguments that increases in NHS expenditure were essential - given the condition of the capital stock, the arrears in capital development, and the need to keep pace with medical teaching and research - so that the government should relinquish responsibility for health services if it could not accept the financial implications (5.6), the political
consequences of financing such increases by granting large supplementary estimates were potentially serious. The government would be open to accusations that they were unable effectively to control public expenditure and so steps had to be taken to rebut such criticisms (5.7); one direct consequence of this was the imposition of closer scrutiny of the expenditure of HMCs and RHBs (5.8). A more fundamental indecision was also evident in the Cabinet at this time, concerning the financing of the NHS. Were charges to be introduced - thus breaching the principle of a health service free at the time of use - or was finance to come entirely from direct taxation? Put rather more baldly, were essentially economic considerations to take precedence over the social reformist principles upon which the NHS had been introduced? Political problems would arise in both cases; the imposition of charges would be a 'shock to (the government's) supporters... and a grave disappointment to Socialist opinion throughout the world', but there was an 'equal political danger in allowing expenditure ... to continue unchecked' (5.9). In terms of policy formulation, as Offe (1975b, 246) graphically puts it, 'the necessary had become impossible and the impossible necessary'. The political crisis posed by this situation was ultimately to split the Labour Cabinet in 1951, provoking the resignations of Bevan and Wilson in protest against a Cabinet decision to limit NHS expenditure financed from direct taxation in 1951-1952 to £400 million. The balance of the estimate of £423 million was to be made up by the imposition of charges for some NHS appliances (£13 million) and economies of £10 million on the hospital service. The ministerial resignations referred to (see Foot, 1973, for a fuller account) resulted from the refusal of the Cabinet to
reduce defence expenditure in order to avoid the imposition of charges (5.10). Thus, faced with rising demand for and expenditure on the NHS, and at the same time under pressure to expand defence commitments, the Labour government resolved the situation by imposing a limited range of NHS charges, reducing the estimates for the hospital service, and seeking strict control of NHS expenditure.

While it would be possible to give account of the above discussions in terms of personal disputes between Cabinet members - in particular, the well-documented animosity between Bevan and Gaitskell (the Chancellor of the Exchequer) (see Foot, 1973, 291-298, 319-322) - such an account would ignore the constraints under which the Labour government was operating. Moreover, the transition to production of health services for use, rather than for exchange, posed serious problems in terms of the criteria according to which the NHS was to be run. The resources allocated to the NHS owed less to any conception of need for the service than to a variety of ad hoc political demands, being limited to £400 million to accommodate the expanding defence programme. In turn these restrictions were to have important implications for local planning (see section 5.4) but before discussing these, consideration is given to the emergence of the 1962 Hospital Plan.

5.3 The emergence of the Hospital Plan.

This can be accounted for by reference to three important developments. Firstly, the Conservative government in the 1950s sought to rationalise NHS expenditure and run the service more 'efficiently'; in this context an expanded capital investment programme seemed to offer a means of improving the
'efficiency' and throughput of the hospital system. Secondly, the changing character of the British state in the late 1950s - exemplified by the adoption of long-term planning of public expenditure - created a climate in which major public investment programmes were seen as playing an important role in economic management. Finally, on a technical level, various studies suggested that a more efficient use of fewer hospital beds was both desirable and possible.

As noted above (section 5.2) rising NHS costs had given cause for concern since the inception of the service. While in opposition, the Conservatives had attacked rising NHS estimates as an example of socialist inefficiency and waste (5.11). It was therefore not surprising that, on returning to office, the Conservatives set up an inquiry into the cost of the NHS, though no attempt was made to reprivatise the service. Jessop (1980) argues that this resulted from their wish to retain the leverage on demand management provided by a large welfare state. Thus, despite protests to the effect that, by setting up an inquiry, the Conservatives were 'seeking another instrument by which (they) could mutilate the service' (5.12), no drastic action was taken; efforts were made to trim the welfare state to 'what the economy could afford' (Gamble, 1974, 63-64; see also Pliatzky, 1982, 20-21), and health authorities were requested to use hospital beds more efficiently (5.13).

The report of the Committee of Inquiry into the cost of the NHS (Guillebaud Committee, 1956) demonstrated that the share of GNP accounted for by the service had actually declined between 1949-1950 and 1953-1954 (table 5.1); likewise, NHS capital investment - expressed as a proportion of gross fixed capital formation - had also fallen (table 5.2). Moreover, hospital capital investment in 1952-1953 was estimated to be
only 32% of the corresponding figure for 1938-1939 (Abel-Smith and Titmuss, 1956, 52). In this light it is not surprising that the Committee recommended a substantial expansion of hospital capital investment, particularly since the Minister of Health - Ian MacLeod - had identified the 'thrusting needs of the hospital service' as perhaps the major problem for the NHS (5.14). The Guillebaud Committee was emphatic in its recommendation that an expanded capital investment programme, of the order of £30 million per annum, would generate important savings in current expenditure. Such savings were of particular importance given the tendency for health-service costs to rise faster than in more capital-intensive sectors of the economy. This tendency had developed not only because of rising demand (due to demographic change and provision of a free service) but also because of the labour-intensive nature of the NHS. Since wages in the health service cannot, in principle, be permitted to lag too far behind those in other sectors of the economy - if only because of the difficulties this would create in terms of attracting labour - then pressure on costs is a permanent feature of the NHS (Manson, 1980). Indeed Gough (1975, 63) claims that the cost of service industries must rise annually in order to preserve existing standards of service - in real terms. Hence the importance of the Guillebaud Report's (1956,116) suggestion that increased capital investment could reduce current expenditure via more efficient provision of services and deployment of manpower. For example, their analyses had shown that capital investment of £650,000 could generate annual savings in current expenditure of £213,000 (Abel-Smith and Titmuss, 1956, 136). Finally, the Guillebaud Committee argued
Table 5.1  Gross cost of the NHS\(^{(1)}\) as a proportion of GNP in England and Wales, 1948-1949 to 1953-1954.

<table>
<thead>
<tr>
<th>Year</th>
<th>GNP (£m; actual prices)</th>
<th>Gross cost of the NHS (£m; actual prices)</th>
<th>Gross cost as percentage of GNP.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1948-49</td>
<td>9,349</td>
<td>333.2</td>
<td>3.57</td>
</tr>
<tr>
<td>1949-50</td>
<td>9,907</td>
<td>376.6</td>
<td>3.80</td>
</tr>
<tr>
<td>1950-51</td>
<td>10,539</td>
<td>395.7</td>
<td>3.75</td>
</tr>
<tr>
<td>1951-52</td>
<td>11,560</td>
<td>411.7</td>
<td>3.56</td>
</tr>
<tr>
<td>1952-53</td>
<td>12,487</td>
<td>436.7</td>
<td>3.50</td>
</tr>
<tr>
<td>1953-54</td>
<td>13,273</td>
<td>453.4</td>
<td>3.42</td>
</tr>
</tbody>
</table>

Source: Abel-Smith and Titmuss, 1956, 60.

Notes
1. 'Gross cost' refers to the cost of the service before deduction of charges.
2. Annual rate; interpolated from the part of the year for which the NHS operated.
Table 5.2  Cost of new fixed assets in the NHS as a proportion of gross fixed capital formation, England and Wales, 1948-1949 to 1953-1954.

<table>
<thead>
<tr>
<th>Year</th>
<th>(1) Gross fixed capital formation (£m; actual prices)</th>
<th>(2) Expenditure on new fixed capital assets in the NHS (£m; actual prices)</th>
<th>(2) as percentage of (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1948-49(2)</td>
<td>1,295</td>
<td>10.4</td>
<td>0.80</td>
</tr>
<tr>
<td>1949-50</td>
<td>1,419</td>
<td>11.8</td>
<td>0.83</td>
</tr>
<tr>
<td>1950-51</td>
<td>1,532</td>
<td>11.6</td>
<td>0.76</td>
</tr>
<tr>
<td>1951-52</td>
<td>1,689</td>
<td>12.5</td>
<td>0.74</td>
</tr>
<tr>
<td>1952-53</td>
<td>1,874</td>
<td>11.9</td>
<td>0.64</td>
</tr>
<tr>
<td>1953-54</td>
<td>2,084</td>
<td>11.1</td>
<td>0.53</td>
</tr>
</tbody>
</table>

Source: Abel-Smith and Titmuss, 1956, 49.

Notes:
1. Gross fixed capital formation is taken as 89% of that for Great Britain, interpolated into financial years.
2. Annual rate: interpolated from the part of the year for which the NHS operated.
for a relaxation of some of the constraints under which health authorities had to operate, advocating a raising of the limit (in cash terms) below which capital schemes did not require Treasury approval from £30,000 to £100,000 (1956, 85), and proposing notification of capital allocations over three years rather than on an annual basis, to facilitate forward planning (Guillebaud Committee, 1956, 120-121).

Clearly then, the potential contribution of an expanded hospital capital investment programme had been recognised. Subsequently, political pressures for such an expansion derived from various sources. Thus the medical profession voiced their increased anxiety at the deteriorating condition of the hospitals and at the apparent lack of action to rectify the situation; they also pointed to the relative priority accorded to education and housing in postwar reconstruction, and therefore pressed for much higher allocations to hospital development (e.g. Abel and Lewin, 1959, 110). The policy of the BMA - articulated at its annual conference in 1959 - was for an expansion of the hospital building programme to around £750 million, spread over ten years (5.15). Furthermore, it is clear that an expansionist public expenditure policy was pursued by the Conservatives in the late 1950s (Brittan, 1969, 115-118) and this had spinoffs in the form of a slow expansion of hospital building. One feature of this was the allocation of central government finance - as distinct from the normal allocations to RHBs - to major capital projects identified as being urgent. This allowed the Newcastle RHB to commence construction of the West Cumberland Hospital (see below, section 5.4). The hospital capital programme continued to expand in the late 1950s, but perhaps the major stimulus towards the Hospital Plan derived
from the reorganisation of the British state apparatus that occurred at that time.

The postwar 'settlement' in Britain was characterised by the introduction of macro-level demand management in a mixed economy, and by a large-scale expansion of social welfare programmes. However, a variety of factors exposed the limitations of both forms of intervention and led to an interest in alternative strategies for economic management (see Jessop, 1980, 38-40; CSE State Group, 1979, 6-7). The principal change was the introduction of long-term economic planning following the Plowden Report (1961), based on firmer public expenditure control through the Public Expenditure Survey Committee (PESC) system, whereby expenditure was controlled in five-year rolling programmes. Such measures had gained substantial support within the Treasury and the Federation of British Industries, the more so since the Treasury was anxious to introduce labour-saving investment, both to reduce running costs and release labour to facilitate fuller utilisation of industrial capacity (Brittan, 1969, 148-153, 155). The emergence of the Hospital Plan should therefore be seen against this background. Before the 1959 election all the major political parties had committed themselves to an expanded hospital building programme; this would generate savings in NHS current expenditure and fit in with moves towards long-term public expenditure planning; and there had been significant pressures from the medical profession for investment in hospitals.

The Hospital Plan therefore resulted both from the realisation that an expanded capital building programme could play a valuable part in economic planning - not least because completion rates of houses and schools had slackened slightly - and also because of the potential for saving on current
expenditure via plant replacement and closure of obsolete and inefficient units. However, the precise form to be taken by the Plan seems to have been settled largely at a technical level; two factors were important here.

Firstly, various studies of the relationship between total population and numbers of hospital beds (summarised in table 5.3) suggested that hospital planning should be based on a somewhat smaller beds/population ratio than had formerly been the case. The initial intention of providing 7.0 acute beds per 1,000 population (5.16) seemed unrealistic in the light of the limited resources available for capital development; in 1960, for instance, 3.9 beds were available per 1,000 population in England and Wales (Ministry of Health, 1962, 274). In the light of the evidence of these studies a 'bed norm' of 3.3 beds/1,000 population was favoured, though this was subsequently challenged on the grounds of its arbitrary nature (Allen, 1979).

Secondly, technical developments in hospital planning emphasised the importance of flexibility in design, economies of scale in service provision, and comprehensiveness of service (Abel and Lewin, 1959; Godber, 1958; 1959; Farrer-Brown, 1959), and stressed the importance of integrating the work of the hospitals with the rest of the health service (McKeown, 1959; Fry, 1959). Concepts such as that of the 'area hospital' (Abel and Lewin, 1959, iii) were aired; such facilities were to serve every 'natural area' of population and this concept has clear affinities with the 'base hospital' proposals discussed above (chapter 4). These views received official acceptance in the Hospital Plan's concept of the District General Hospital (DGH), of 600-800 beds, serving populations
Table 5.3 Summary of estimates of 'norms' for acute hospital provision.

<table>
<thead>
<tr>
<th>Estimate produced by:</th>
<th>Date of study</th>
<th>Recommended Norm (beds/1000 pop.)</th>
<th>Study area</th>
<th>Source(1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ministry of Health</td>
<td>Unknown</td>
<td>7.0</td>
<td>Unknown</td>
<td>RHB(48)1</td>
</tr>
<tr>
<td>Nuffield Provincial Hospitals Trust</td>
<td>1945-46</td>
<td>4.5-6.4</td>
<td>Hospitals Surveys (various regions)</td>
<td>Ministry of Health, 1946.</td>
</tr>
<tr>
<td>Barr, V.</td>
<td>1957</td>
<td>2.0</td>
<td>Reading</td>
<td>Barr, 1957.</td>
</tr>
</tbody>
</table>

Notes
1. 'Source' refers to the references in which these studies are discussed, with the exception of RHB (48)1, which is a Ministry of Health Circular (on the Development of Specialist Services) and so is not referenced separately in the Bibliography.
Thus the origins of the Hospital Plan can be traced to the desire of the Conservative government to run the NHS in what they perceived to be a more efficient fashion. Specific political pressures for increased hospital capital investment stemmed from various sources, including the major political parties and the BMA, and an expanded building programme was clearly in accord with the contemporary interest in long-term economic planning. Finally, both the Guillebaud Report and a variety of technical studies had demonstrated the desirability - in terms of reducing current expenditure - of an expansion in hospital building. Having thus outlined the context against which the discussion of local planning of the hospital services in the Newcastle RHB must be interpreted, the next section considers developments in this area from 1948-1962.

5.4 Hospital planning in the Newcastle RHB, 1948-1962.

Four issues are discussed here, namely: the difficulties posed for local planners by financial restraint on the part of central government; the sub-regional distribution of capital expenditure; the scale of capital projects accomplished by the RHB; and the redistribution of medical manpower. Emphasis will be laid on the first of these, since it is most directly concerned with the process of policy-making; the latter three points relate to the outcomes of that process. Figure 5.1 shows the area served by the Newcastle RHB, with its constituent HMCs.
Figure 5.1: The Newcastle RMB and its constituent HMCs
Limited availability of labour and scarcity of construction materials severely constrained hospital development in the early postwar years. In particular, new capital development was minimal (5.17) due to the small amounts of materials made available to RHBs (table 5.4). The finance available to the Newcastle RHB for capital development in its first two years - about £560,000 per annum - was of a similar order to the prewar situation. However, this was 'quite inadequate' in the light of the additional demand released by the introduction of a comprehensive health service, particularly since virtually no new construction (apart from EMS units - see chapter 4) had taken place between 1939 and 1948 (5.18). Since no major capital development was possible, the RHB felt that a considerable amount of minor - and probably 'futile' - capital works would be necessary (5.19). In such circumstances, developments would be geared largely to prolonging the life of the existing capital stock (5.20); this was likely to lead to hospitals becoming 'architectural hotch-potches', as small-scale projects were added as and where possible (5.21).

Such problems were further compounded by the budgeting difficulties arising from uncertainty as to future capital allocations, and from close central government monitoring of NHS expenditure (imposed as a response to the political crisis discussed above - section 5.2) from April 1950. Under the 'Limit and Control of Expenditure' circular, HMCs and RHBs were obliged to submit monthly statements of expenditure; cases in which the approved estimates were likely to be exceeded would undergo Ministerial scrutiny (5.22). Moreover, in planning future capital developments, works which were not
Table 5.4 Projected allocations of controlled construction materials to RHBs for the first quarter of 1949

<table>
<thead>
<tr>
<th>RHB</th>
<th>Steel (tons)</th>
<th>Cast Iron (tons)</th>
<th>Soft-wood (standards)</th>
<th>Hard-wood (cu. ft.)</th>
<th>Ply-wood (cu. ft.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newcastle</td>
<td>46</td>
<td>20</td>
<td>20</td>
<td>520</td>
<td>3,650</td>
</tr>
<tr>
<td>Leeds</td>
<td>56</td>
<td>24</td>
<td>24</td>
<td>640</td>
<td>4,450</td>
</tr>
<tr>
<td>Sheffield</td>
<td>63</td>
<td>27</td>
<td>27</td>
<td>720</td>
<td>5,050</td>
</tr>
<tr>
<td>E.Anglia</td>
<td>28</td>
<td>12</td>
<td>12</td>
<td>320</td>
<td>2,250</td>
</tr>
<tr>
<td>N.W.Metropolitan</td>
<td>63</td>
<td>27</td>
<td>27</td>
<td>720</td>
<td>5,050</td>
</tr>
<tr>
<td>N.E. Metropolitan</td>
<td>53</td>
<td>22</td>
<td>22</td>
<td>600</td>
<td>4,200</td>
</tr>
<tr>
<td>S.E. Metropolitan</td>
<td>56</td>
<td>24</td>
<td>24</td>
<td>640</td>
<td>4,500</td>
</tr>
<tr>
<td>S.W. Metropolitan</td>
<td>84</td>
<td>36</td>
<td>36</td>
<td>960</td>
<td>6,700</td>
</tr>
<tr>
<td>Oxford</td>
<td>23</td>
<td>10</td>
<td>10</td>
<td>260</td>
<td>1,800</td>
</tr>
<tr>
<td>South West</td>
<td>50</td>
<td>22</td>
<td>22</td>
<td>580</td>
<td>4,050</td>
</tr>
<tr>
<td>Birmingham</td>
<td>70</td>
<td>30</td>
<td>30</td>
<td>800</td>
<td>5,600</td>
</tr>
<tr>
<td>Manchester</td>
<td>73</td>
<td>31</td>
<td>31</td>
<td>840</td>
<td>5,900</td>
</tr>
<tr>
<td>Liverpool</td>
<td>35</td>
<td>15</td>
<td>15</td>
<td>400</td>
<td>2,800</td>
</tr>
<tr>
<td>Boards of Governors</td>
<td>100</td>
<td>50</td>
<td>40</td>
<td>200</td>
<td>9,000</td>
</tr>
<tr>
<td>Continu- gencies</td>
<td>450</td>
<td>200</td>
<td>160</td>
<td>800</td>
<td>35,000</td>
</tr>
<tr>
<td>RHB Total</td>
<td>700</td>
<td>300</td>
<td>300</td>
<td>8,000</td>
<td>56,000</td>
</tr>
<tr>
<td>Total Allocation</td>
<td>1,250</td>
<td>550</td>
<td>500</td>
<td>9,000</td>
<td>100,000</td>
</tr>
</tbody>
</table>

Source: RHB (48) 54
essential or urgent were not to be considered:

'the broad test is whether the development... will effectively and economically assist in meeting a really important deficiency'. (5.23)

Planning for immediate needs, rather than long-term strategic goals, was therefore the order of the day. Even this was further hampered by budgeting problems; for instance, balances not spent in one financial year could not be carried forward into the next year (5.24). Furthermore, ad hoc reductions in capital allocations (5.25) limited the RHB's scope for strategic planning. Thus the RHB's capital allocation for 1951-1952 was reduced by 25% shortly before the end of the 1950-1951 financial year (5.26), and the RHB claimed that this had effectively halved their programme, when the effects of rising building costs were taken into account. This was because the RHB's allocation had been reduced from £700,000 to £480,000 of which only 85% (£405,000) could be spent; the latter restriction had been imposed to reduce the risk of overspending on capital accounts (5.27). Such restrictions engendered 'considerable irritation' among RHBs and HMCs at their lack of autonomy in planning (Guillebaud Committee, 1956, 104). Indeed the Newcastle RHB argued that, in the absence of assurances that funds would be available for proposed schemes, planning was an activity which:

'raises false hopes, engenders a sense of frustration, and degenerates into a theoretical exercise without purpose or justification... the course of the Board's programme... has been from crest to trough of successive waves of hope and disappointment'. (5.28)

The RHB was further constrained by a capital allocation which, on a per capita basis, was claimed to be 23% below the national average (5.29); the RHB consequently argued that:
'there can be no justification, in a national hospital service, for maintaining grossly different standards of hospital service in different parts of the country'. (5.30)

Furthermore, without producing supporting evidence (but see chapter 4), the RHB argued that hospital development in their area had proceeded more slowly than in other parts of the country (5.31) and therefore pressed the Ministry of Health to adjust their capital allocation accordingly (5.32). The existence of regional disparities in service provision was formally recognised in 1952 (5.33) and indeed the Newcastle RHB's position subsequently improved slightly vis-a-vis other regions (table 5.5), though care should be taken in interpreting this table as it is based only on each RHB's basic allocation. Consequently it does not include information on schemes financed directly from central funds.

As for developments within the Newcastle RHB, at least three responses were made to the uncertain financial situation. Firstly, to avoid overspending, the RHB attempted to slow down the pace of its capital programme by ceasing its practice of 'constantly pressing the contractors to proceed with the work with the utmost expedition' (5.34). Secondly, to facilitate some small-scale improvements to services throughout the region, the RHB allocated a small proportion of its funds to minor capital building works. Originally set at £2 per bed per annum, this was, however, reduced to £1 per bed in 1951 and was a casualty of the 25% reduction in capital expenditure in 1951 (5.35). Thirdly, early in 1952, the RHB requested its constituent HMCs to suggest hospitals which might be closed to ease the financial situation. Perhaps not surprisingly, the response to this was negative; thus the
Table 5.5 Intended basic capital allocations to RHBs, 1951(1)-1962.

<table>
<thead>
<tr>
<th>RHB</th>
<th>Year</th>
<th>(£'000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newcastle</td>
<td>600</td>
<td>480</td>
</tr>
<tr>
<td>Leeds</td>
<td>600</td>
<td>480</td>
</tr>
<tr>
<td>Sheffield</td>
<td>800</td>
<td>640</td>
</tr>
<tr>
<td>East Anglia</td>
<td>350</td>
<td>280</td>
</tr>
<tr>
<td>N.W. Metropolitan</td>
<td>700</td>
<td>560</td>
</tr>
<tr>
<td>N.E. Metropolitan</td>
<td>700</td>
<td>560</td>
</tr>
<tr>
<td>S.E. Metropolitan</td>
<td>700</td>
<td>560</td>
</tr>
<tr>
<td>S.W. Metropolitan</td>
<td>1000</td>
<td>800</td>
</tr>
<tr>
<td>Oxford</td>
<td>300</td>
<td>240</td>
</tr>
<tr>
<td>S. Western</td>
<td>550</td>
<td>440</td>
</tr>
<tr>
<td>Birmingham</td>
<td>800</td>
<td>640</td>
</tr>
<tr>
<td>Manchester</td>
<td>800</td>
<td>640</td>
</tr>
<tr>
<td>Liverpool</td>
<td>400</td>
<td>320</td>
</tr>
<tr>
<td>Wales</td>
<td>550</td>
<td>440</td>
</tr>
<tr>
<td>Wessex (2)</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Source: Ministry of Health circulars

Notes:
1. Data for 1948-1951 not available
2. This RHB was part of the S.W. Metropolitan RHB until 1960
Durham HMC stressed the industrialised nature of central Durham and the underdevelopment of local hospital services, and therefore objected to hospital closures unless the financial position should become acute. Likewise, in the opinion of the Newcastle HMC, no useful purpose would be served by indicating priorities for hospital closures (5.36).

Clearly, then, considerable problems were experienced in setting in motion a programme of capital development in the region's hospitals; the results can be illustrated by a consideration of the use of capital resources by the RHB, and by discussing the outcomes of its policies. Firstly, the amount of new construction achieved prior to 1962 was minimal; the proportion of the RHB's capital allocated to this varied between 1.1% and 19.7%, though not until 1957 did this rise above 10% in any one year (figure 5.2). In this respect the RHB's experience was very similar to the national situation (figure 5.3). Given the limited resources available, the RHB felt unable to concentrate development on a few of its priorities; rather, investment was in the form of small-scale projects (table 5.6), though this in turn led to concern that the Board's programme had degenerated into a number of extremely small works (5.37). Moreover, there was little scope for replacing the EMS hospitals, for this would have required large investment in view of the size of those hospitals (5.38).

The implications of these developments for the intra-regional pattern of capital investment were twofold. Firstly, the RHB had identified several priorities for capital development, including three new hospitals - for West
Table 5.6  Value and number of capital building
or engineering schemes carried out by the
Newcastle RHB, 1948-1950(1).

<table>
<thead>
<tr>
<th>Value of Scheme (£)</th>
<th>Completed at 31.3.50</th>
<th>In progress at 31.3.50</th>
</tr>
</thead>
<tbody>
<tr>
<td>500</td>
<td>23</td>
<td>-</td>
</tr>
<tr>
<td>501-1000</td>
<td>56</td>
<td>25</td>
</tr>
<tr>
<td>1001-2500</td>
<td>46</td>
<td>20</td>
</tr>
<tr>
<td>2501-5000</td>
<td>27</td>
<td>29</td>
</tr>
<tr>
<td>5001-10000</td>
<td>3</td>
<td>25</td>
</tr>
<tr>
<td>10001-20000</td>
<td>2</td>
<td>18</td>
</tr>
<tr>
<td>20000</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

Source: 

Note: 
1. The time period referred to is from the inception of the NHS (5.7.48) to the end of the financial year 1949-1950 (31.3.50).
(top) **Figure 5.2: Use of capital, Newcastle RHB, 1948-1962**

(bottom) **Figure 5.3: Use of NHS capital, 1948-1962**

**Note:** disaggregation of capital accounts was changed in 1958/59; hence the breaks in these figures.
Cumberland, Peterlee and the Bedlington area - and 14 major extensions (figure 5.4). Yet not until 1955, following a Government announcement of an increase in the proportion of capital resources allocated to large-scale developments (5.39), were the RHB able to commence construction of the new West Cumberland Hospital, though the Bedlington and Peterlee projects never came to fruition for various reasons (5.40).

As the building programme expanded in the late 1950s, progress was made on several major schemes. Major capital developments completed in the acute hospital sector between 1948 and late 1961 are shown in figure 5.5.

Secondly, the distribution of expenditure between HMCs is of interest. This is summarised in graphs of five-year moving averages of per capita expenditure by HMC, standardised as a proportion of the regional average per capita expenditure (figure 5.6 a-d). Moving averages were employed to smooth out the effect of particularly large investments in individual years, and the figures were standardised as a proportion of the regional average in order to obtain an indication of the relative extent to which particular HMCs benefited from the RHB's capital investment programme. Care must be taken in interpreting these figures. For example, small HMCs in which a relatively minor project was being carried out can appear to be receiving a large allocation; witness the experience of Hexham HMC in the early years of the NHS. What is clear, however, is the relative progress made in some areas - particularly West Cumberland - while others (South Shields, Darlington, Sunderland) lagged behind. Apart from the priority schemes noted above, however, little information was available concerning the RHB's priorities for capital development, with one exception. Teesside had been identified as a future
Figure 5.4: Newcastle RHB: priorities for hospital development
Figure 5.5: Major capital investments in non-psychiatric hospitals in Newcastle RHB, 1948-1962.
growth point for industry within the region for some time (see Pepler and Macfarlane, 1949, 157-161), and in the case of hospital planning some indication of its importance can be gleaned from the following; at a meeting of the RHB's Planning Committee in December 1953, it was reported that:

'in view of the importance of the developments of the Teesside industries (which had been endorsed by the Ministry of Town and Country Planning, the Board of Trade and the Ministry of Labour)... (Cleveland HMC) felt that... the proposed developments at Middlesbrough should be undertaken at the earliest date... major industrial expansion had taken place in respect of chemicals and heavy industries, and extensive additional expansion was planned (5.41).

This matter was stressed at several subsequent meetings of the RHB's Planning Committee (5.42) and two direct consequences were: firstly, that Teesside became regarded as a higher priority than Peterlee (see chapter 8), and secondly, in anticipation of developments on Teesside, the Sedgefield HMC was merged with part of Cleveland HMC, it being recognised that Sedgefield General Hospital would become 'largely redundant' in the event of a new general hospital being built in the north Teesside area (5.43). Although Teesside had clearly become established as a priority of the RHB, the effect of this on the intraregional pattern of investment was not fully apparent until the late 1960s (see figure 5.6). Thirdly, in terms of specific patterns of openings and closures of hospitals, a corollary was that the only new hospital to be commenced was the West Cumberland Hospital. New bed provision was confined largely to Cumberland and Teesside (figure 5.7). Hospital closures were confined largely to buildings whose physical condition was such that no benefits would accrue from their retention, and to
Per capita investment (as a proportion of the regional average) (log scale)

Source: Newcastle RHB Annual Accounts

N W Durham  Berwick  Alnwick  Wansbeck  Sunderland

Northallerton  E Cumberland  W Cumberland  Durham  Darlington

Figure 5.6 a, b: Five-year moving averages of per capita investment in non-psychiatric hospitals by HMC, 1950-1974.
Figure 5.6 c,d: Five-year moving averages of per capita investment in non-psychiatric hospitals by HMC, 1950-1974.

Note: data for Newcastle HMC are incomplete due to its merger with the Board of Governors of the Teaching Hospitals in 1971.
tuberculosis and isolation units (figure 5.7). Many of the latter were unsuitable because of their physical condition, but changing medical attitudes to the treatment of infectious disease meant that a rapid concentration of these units was seen as desirable; indeed, this had been anticipated by the Hospital Surveyors (Ministry of Health, 1946 (volume 10), 22-29). Tuberculosis, on the other hand, had been virtually eliminated a few years after World War 2, and this was reflected in growing concern at the under-utilisation of several hospitals (5.44).

However, if little progress could be made on capital investment, the RHB compensated for this by a redistribution of medical manpower and by recruiting additional staff (table 5.7). In the absence of the necessary capital resources, of course, the RHB were virtually forced to do this; at a Board meeting in 1949, it was observed that:

'it was impossible to get new buildings but the one thing that could be obtained was good doctors in the hospitals' (5.45).

By 1957, the RHB felt that the region was well staffed and that its specialist establishment was 80% of what it ought to be (5.46). This, in turn, was accompanied by a considerable increase in the efficiency of the service, measured in terms of patient throughput (table 5.8). In total, the number of inpatient discharges rose from 155,550 to 208,063 (33.7%), from 1949-1953, against an increase in the number of staffed beds of only 5.9%. This improvement was still more marked in certain HMCs (e.g. Sedgefield, Durham, Northallerton, S.W. Durham) where considerable increases occurred in the number of patients discharged per staffed bed.
Figure 5.7  Provision of new hospital accommodation and closures of hospitals in the Newcastle RHB, 1948-1962.

Sources: Newcastle RHB Annual Accounts, and Ministry of Health Hospital Building Progress Report No. 1
Table 5.7 Distribution of new specialist appointments by HMC within Newcastle RHB, 1948-1954.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Newcastle</td>
<td>14</td>
<td>7</td>
<td>5</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Gateshead</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>South Shields</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>S.E. Northumberland</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Hexham</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Berwick</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Alnwick and Rothbury</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Wansbeck</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>N.W. Durham</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>6</td>
<td>-</td>
</tr>
<tr>
<td>Sunderland</td>
<td>9</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Hartlepool</td>
<td>4</td>
<td>7</td>
<td>-</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Cleveland)</td>
<td>6</td>
<td>13</td>
<td>3</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Teesside</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sedgefield</td>
<td>1</td>
<td>-</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>S.W. Durham</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Durham</td>
<td>7</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Darlington</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Northallerton</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>E.Cumberland</td>
<td>5</td>
<td>-</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>W. Cumberland</td>
<td>6</td>
<td>-</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>74</strong></td>
<td><strong>52</strong></td>
<td><strong>35</strong></td>
<td><strong>41</strong></td>
<td><strong>17</strong></td>
</tr>
</tbody>
</table>

Source:
Newcastle RHB Annual Reports
Table 5.8 Comparison of numbers of staffed beds, inpatient discharges, and discharges per bed in Newcastle RHB for 1949 and 1953.

<table>
<thead>
<tr>
<th>HMC</th>
<th>Number of staffed beds</th>
<th>Discharges of inpatients</th>
<th>Discharges per staffed beds</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1949</td>
<td>1953</td>
<td>% Change</td>
</tr>
<tr>
<td>Newcastle</td>
<td>1737</td>
<td>1724</td>
<td>-0.75</td>
</tr>
<tr>
<td>Gateshead</td>
<td>821</td>
<td>892</td>
<td>+8.6</td>
</tr>
<tr>
<td>S.Shields</td>
<td>966</td>
<td>969</td>
<td>+0.3</td>
</tr>
<tr>
<td>S.E. Northumberland</td>
<td>695</td>
<td>686</td>
<td>-1.3</td>
</tr>
<tr>
<td>Hexham</td>
<td>665</td>
<td>738</td>
<td>+10.9</td>
</tr>
<tr>
<td>Berwick</td>
<td>115</td>
<td>114</td>
<td>-0.09</td>
</tr>
<tr>
<td>Alnwick/Rothbury</td>
<td>49</td>
<td>64</td>
<td>+30.6</td>
</tr>
<tr>
<td>Wansbeck</td>
<td>389</td>
<td>412</td>
<td>+5.9</td>
</tr>
<tr>
<td>N.W. Durham</td>
<td>739</td>
<td>964</td>
<td>+30.4</td>
</tr>
<tr>
<td>Sunderland</td>
<td>2113</td>
<td>2011</td>
<td>-4.9</td>
</tr>
<tr>
<td>Hartlepool</td>
<td>746</td>
<td>747</td>
<td>+0.1</td>
</tr>
<tr>
<td>Cleveland</td>
<td>466</td>
<td>667</td>
<td>+43.1</td>
</tr>
<tr>
<td>Teesside</td>
<td>1375</td>
<td>1475</td>
<td>+7.2</td>
</tr>
<tr>
<td>Sedgefield</td>
<td>418</td>
<td>404</td>
<td>-3.4</td>
</tr>
<tr>
<td>S.W. Durham</td>
<td>617</td>
<td>785</td>
<td>+27.2</td>
</tr>
<tr>
<td>Durham</td>
<td>958</td>
<td>941</td>
<td>-1.8</td>
</tr>
<tr>
<td>Darlington</td>
<td>479</td>
<td>534</td>
<td>+11.4</td>
</tr>
<tr>
<td>North-allerton</td>
<td>304</td>
<td>389</td>
<td>+27.9</td>
</tr>
<tr>
<td>E.Cumberland</td>
<td>922</td>
<td>900</td>
<td>-2.4</td>
</tr>
<tr>
<td>W.Cumberland</td>
<td>370</td>
<td>423</td>
<td>+14.3</td>
</tr>
<tr>
<td>TOTAL</td>
<td>14944</td>
<td>15839</td>
<td>+5.98</td>
</tr>
</tbody>
</table>

Source: Newcastle RHB Annual Reports.
To summarise, the consequences of the financial situation in which the Newcastle RHB found itself in the 1948-1962 period were as follows. Firstly, planning of any long-term development was, initially at least, virtually impossible, given the constraints under which the Board was operating. Thus, developments were confined largely to small-scale schemes, distributed relatively evenly between HMCs; moreover new construction was at a premium. Secondly, little could be done about the various priorities identified for new hospital construction until the late 1950s, by which time planning was taking place on a more long-term basis. From the mid-1950s, the Ministry of Health began to allocate sums of money for major capital developments - hence the West Cumberland hospital project. Finally, and of some importance in terms of the quality of service provided, significant progress was made in the redistribution of medical manpower and the recruitment of additional consultant staff.

5.5 Concluding remarks

This chapter has concentrated on three main issues, namely, the attempts of both Labour (1948-1951) and Conservative (post-1951) governments to restrain NHS expenditure (section 5.2); the factors contributing to an expansion of NHS capital expenditure in the late 1950s and the development of the Hospital Plan (section 5.3); and the implications of these for hospital development in the Newcastle RHB (section 5.4). In this section the themes arising from the foregoing evidence will be reviewed.

At one level, it could be argued that the Labour government was torn between considerations of equity and
efficiency in running the NHS: to what extent was expenditure to be allowed to rise to meet demand, given the imperatives of tight control of public expenditure in the early postwar years? Put rather more boldly, however, it is clear that a variety of political considerations led to a breach with the reformist principles upon which the NHS had been introduced. In particular, strict limitations of NHS expenditure were introduced at the same time as an expansion of defence expenditure, and proposals to introduce charges for certain services provoked a political crisis for Labour, leading to the resignations of Bevan and Wilson from the Cabinet. In this situation, as noted above, necessary decisions had become impossible and the impossible necessary (Offe, 1975b, 246).

While not attempting to reprivatise the NHS, the Conservative government were committed to its rationalisation. The Guillebaud Committee's (1956) report pointed to this by indicating the potential savings in current expenditure that would accrue from an expanded capital development programme. Though there ensued an expansion in NHS capital development, not until 1962 did the Hospital Plan make a significant attempt to redevelop the hospital stock. The emergence of this plan reflected the restructuring of the British state apparatus in response to the perceived failures of Keynesian techniques, one consequence of which was increased state economic planning.

The local consequences were, firstly, that little long-term planning of capital investment was possible in the early years of the NHS; instead, small-scale schemes were developed, geared to patching up the existing capital stock. Intra-regionally the RHB was unable to respond to the priority needs for hospital construction until an expansion of capital
resources permitted a start to be made on the West Cumberland Hospital. However, certain other priorities - such as Peterlee and South-East Northumberland - remained and indeed these slipped down the order relative to the proposals for investment on Teesside. Finally, the RHB made some progress with the redistribution of medical manpower, one further consequence of which was an increase in the efficiency of the service, in terms of patient throughput.

In interpreting the foregoing, it is important to emphasise the changing character of the British state, the selective character of its interventions, and the constraints these imposed on the RHB's activities. In particular, the problems of policy formation inherent in providing services for use (see Offe and Ronge, 1975) were particularly acute at the inception of the NHS; one result of this was the imposition of tight controls on expenditure, on the autonomy of RHBs, and on new hospital development. However, as the potential role of capital investment in economic planning was realised, an expanded hospital building programme became increasingly feasible in political terms. The selective character of state intervention, and the way different political solutions are adopted in different historical circumstances - serving in general, to exclude anti-capitalist interests - is a key point here. Finally, the process of state policy formulation cannot be likened to that of a private entrepreneur. This is graphically demonstrated by the Cabinet debates on NHS expenditure, and its implications for hospital provision and location are essentially that decisions on the resources devoted to hospital development are subject to a variety of socio-political criteria. These decisions are not taken according
to any conception of what the NHS requires; rather, they depend on what solutions to economic crises are seen as appropriate at different points in time.
Footnotes

5.1 PRO CAB 129/34, CP(49)105, 6.5.49.

5.2 PRO CAB 128/15, CM 37(48) 1, 23.5.49 - emphasis added.

5.3 Ibid.

5.4 PRO CAB 129/37, CP(49)221, 8.11.49.

5.5 Ibid. - emphases added.

5.6 PRO CAB 129/38, CP(50)31, 10.3.50.

5.7 PRO CAB 128, CM 10(S0)3, 13.3.50.

5.8 Circular RHB (50)41 (see section 5.4).

5.9 PRO CAB 128, CM 10(S0)3, 13.3.50.

5.10 Minutes of the relevant meetings are held in PRO CAB 128/19, as follows: CM22(51)1; CM25(51)2; CM 26(51)1.

5.11 For example H.C. Deb., 472, c.916 et. seq., 14.3.50.

5.12 A. Bevan, H.C. Deb., 513, c.1230, 1.4.53.

5.13 See, for example, the Annual Report of the Ministry of Health, 1952, 34; and RHB(54) 89.

5.14 I. Macleod, H.C. Deb., 515, c.1730, 18.5.53.


5.16 RHB(48)1 - Development of Specialist Services.

5.17 RHB(48) 54, Hospital Building Work.


5.19 RHB Planning Committee, 22.11.48.

5.20 RHB(48)54, Hospital Building Work.

5.21 RHB Planning Committee, 13.12.48.

5.22 RHB(50)41, National Health Service: Limit and Control of Expenditure.

5.23 RHB(50)80, Revised Estimates for 1950-1951.

5.27 RHB Planning Committee, 26.11.51.
5.30 Ibid., p.15.
5.32 RHB Planning Committee, 25.6.51.
5.33 RHB (52) 97, National Health Service: Revised Capital Estimates for 1952-1953.
5.34 RHB Planning Committee, 12.6.53.
5.35 Newcastle RHB, Third Report (1951-1952) p.73.
5.36 RHB Planning Committee, 13.10.52.
5.37 RHB Planning Committee, 10.3.52.
5.38 The problems of developing the EMS hospitals were discussed inter alia, at RHB Planning Committee meetings held on 22.11.48, 11.4.49, and 24.11.50.
5.39 HM (55) 19, The Hospital Building Programme.
5.40 For the Peterlee evidence see chapter 8.2. In the case of Bedlington the problems arose from the growth of Cramlington new town - at various times this was looked upon favourably as a potential hospital site - and also, more generally, from the problems of finding suitable sites for hospital development in the Wansbeck and S.E. Northumberland HMCs.
5.41 RHB Planning Committee, 18.2.53 - emphasis added.
5.43 Newcastle RHB, Review of Groupings of Hospitals for the Purposes of Management by HMCs - report to the RHBs Planning Committee, 18.1.57.
5.44 RHB Planning Committee, 20.7.58; see also various papers held in RHB 58A and RHB 92.
5.45 RHB Board Meeting, 4.3.49.

6.1 Introduction

Commencing with an outline of the intentions of the 1962 Hospital Plan (section 6.2), this chapter considers the extent to which it was implemented by the Newcastle RHB, up to the time of NHS reorganisation in 1974. Section 6.3 therefore considers policy changes at national level and their implications for the development of the Newcastle RHB's hospital services. Given that the Hospital Plan implied considerable centralisation and concentration of hospital facilities, a further theme of interest relates to the social costs of such development; in addition (due to the large-scale investment involved in constructing DGHs) there were to be major problems in terms of responding to, for instance, the needs of new towns. Hence section 6.4 considers such issues in more detail.

6.2 The proposals of the Hospital Plan

The 1962 Hospital Plan remains the most significant attempt to rationalise and plan the British hospital system. The concept of centralised development of large-scale hospitals can be traced back at least as far as the wartime years (see chapter 4), and despite the effects of public expenditure restraint and changing attitudes to hospital size (chapters 6 and 7) the DGH concept survives to the present day. The Plan's basic proposition was that hospitals should be provided in units of a minimum size of 600-800 beds, to serve populations of 100-150,000 and its logic is perhaps best
captured by the following:

'the district general hospital offers the most practicable method of placing the full range of hospital facilities at the disposal of patients and this consideration far outweighs the disadvantages of longer travel for some patients and their visitors'.

(Ministry of Health, 1962, 6 - emphasis added)

In spatial terms, this clearly envisaged a considerable concentration of hospital services, in the interests of the efficiency of the hospital system as a whole. Thus, while the provision of a system of modern, technologically sophisticated hospitals would involve higher running costs, these increases were to be relatively marginal and, as the Plan explained:

'the real increase in running costs... will be due rather to a higher standard of service than to any increase in the number of beds... opportunities for economy will be created by the concentration of work in fewer centres and the replacement of older buildings by new hospitals which can be more economically maintained and run'.

(Ministry of Health, 1962, 13 - emphasis added)

Put another way, efficiency had clearly triumphed over equity in terms of service provision; if longer travel to hospitals was to be accepted, it had to be justified on the grounds that a better hospital service was being provided. The Plan's aim was therefore to provide a more efficient service - in the sense of increasing patient throughput and restraining running costs - or, as one commentator has argued, to introduce 'capitalist rationality' into the NHS (Manson, 1980, 42). In this sense the Plan's recommendations paralleled proposals being put forward to establish rate of return criteria for nationalised industries (House of Commons, 1961). The Plan's intentions were to be achieved by increasing capital investment to £200 million in its first quinquennium
(1961-1962 to 1965-1966) and to £300 million in its second quinquennium (1966-1967 to 1970-1971). These figures, however, 'did not represent commitments' (Ministry of Health, 1962, 13) and indeed they fell short of the £75 million per annum requested by the BMA in 1959. The Plan would involve constructing 90 new and 134 remodelled hospitals, 356 other schemes each worth over £100,000, and the closure of 709 non-psychiatric hospitals; 41 of the latter were in the Newcastle RHB. The Plan also implied resource redistribution at the inter- and intra-regional scales.

Inter-regionally, the Plan sought to redress some of the imbalances in service provision generated by the uncoordinated historical development of the hospital system. This would be achieved by setting 'bed norms' of 3.3 acute beds per 1000 population (see chapter 5.3).

Table 6.1 shows the variations that existed in availability of acute facilities and gives details of proposed expenditure by region on schemes to commence between 1961-1962 and 1970-1971. Considerable variation in development was envisaged, both to rationalise the existing capital stock (e.g. in the Liverpool RHB) and provide for the influxes of population anticipated in certain areas (for example in the Oxford and Wessex RHBs). From the tables it is clear, that in terms of bed availability, the Newcastle RHB was slightly over-provided relative to many regions, and that the anticipated investment in it was comparable with most other RHBs. However, due to problems of data availability, resource allocation at the inter-regional scale is not considered further (6.1).

While the Newcastle RHB could thus be held to be typical
Table 6.1 Summary of actual and intended distribution of acute beds, and proposed capital investment resulting from the Hospital Plan, by region.

<table>
<thead>
<tr>
<th>RHB</th>
<th>Acute Beds (1960)</th>
<th>Beds/1000 Pop. (1975)</th>
<th>Estimated Total Capital Investment (£'000)</th>
<th>Investment per Head of 1975 Pop.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Available</td>
<td>Proposed</td>
<td>Available in 1960</td>
<td>Proposed (1975)</td>
</tr>
<tr>
<td>Newcastle</td>
<td>11475</td>
<td>10770</td>
<td>3.8</td>
<td>3.4</td>
</tr>
<tr>
<td>Leeds</td>
<td>11836</td>
<td>10860</td>
<td>3.8</td>
<td>3.4</td>
</tr>
<tr>
<td>Sheffield</td>
<td>13501</td>
<td>14160</td>
<td>3.1</td>
<td>3.0</td>
</tr>
<tr>
<td>E. Anglia</td>
<td>4581</td>
<td>4960</td>
<td>3.0</td>
<td>2.9</td>
</tr>
<tr>
<td>Metropolitan RHBs</td>
<td>58529</td>
<td>53340</td>
<td>4.2</td>
<td>3.6</td>
</tr>
<tr>
<td>Wessex</td>
<td>5926</td>
<td>6450</td>
<td>3.6</td>
<td>3.3</td>
</tr>
<tr>
<td>Oxford</td>
<td>5336</td>
<td>6410</td>
<td>3.3</td>
<td>3.3</td>
</tr>
<tr>
<td>South</td>
<td>10627</td>
<td>9930</td>
<td>3.7</td>
<td>3.3</td>
</tr>
<tr>
<td>Western</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birmingham</td>
<td>15671</td>
<td>16130</td>
<td>3.3</td>
<td>3.1</td>
</tr>
<tr>
<td>Manchester</td>
<td>15908</td>
<td>15880</td>
<td>3.6</td>
<td>3.4</td>
</tr>
<tr>
<td>Liverpool</td>
<td>12388</td>
<td>8590</td>
<td>5.6</td>
<td>3.5</td>
</tr>
<tr>
<td>Wales</td>
<td>11623</td>
<td>9310</td>
<td>4.5</td>
<td>3.5</td>
</tr>
<tr>
<td>England &amp; Wales</td>
<td>179456</td>
<td>168550</td>
<td>3.9</td>
<td>3.4</td>
</tr>
</tbody>
</table>


Notes:
1. These figures include £61,400,000 for provincial Teaching Hospitals and £67,800,000 for the London Teaching Hospitals.
2. This figure includes 2055 beds in London's Teaching Hospitals used by patients from outside the Metropolitan regions; these beds were not included in the regional figures.
of provincial RHBs, the main planning problems within the region concerned not so much an overall deficiency in bed numbers but rather that hospitals were inconveniently located and composed of old or unsuitable buildings. Thus table 6.2, showing the age distribution of hospital accommodation within the region, demonstrates that in terms both of new hospital construction and expansion or redevelopment of existing services, the hospital system was partly obsolescent. Over half the hospitals dated from the 19th century and these would be replaced with a small number of DGHs providing a full range of specialist services (Ministry of Health, 1962, 17). Most of the smaller facilities would ultimately close, thus increasing the average size of hospitals within the RHB from 107.2 beds to 156.6 beds (table 6.3); likewise, 46 of the 72 hospitals built before 1900 were ultimately to be closed. Figures 6.1 and 6.2 illustrate, respectively, the hospitals available in 1960 and those to be available by 1975.

Thus the Hospital Plan was introduced as a result of a combination of the technical and political developments discussed above (chapter 5), with the intention of redistributing NHS resources between regions and concentrating facilities at the intra-regional level. The extent to which the Plan was implemented, and the problems encountered in putting it into operation, are both illustrative of the state's ability to achieve its declared objectives; such issues therefore occupy the bulk of this chapter, and indeed the three local case studies all, in various ways, illustrate how health authorities coped with demands for departures from the Plan.
Table 6.2  Age of acute hospitals in the Newcastle RHB.

<table>
<thead>
<tr>
<th>Date of Construction</th>
<th>Number of hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-1860</td>
<td>14</td>
</tr>
<tr>
<td>1880-1879</td>
<td>30</td>
</tr>
<tr>
<td>1880-1899</td>
<td>28</td>
</tr>
<tr>
<td>1900-1919</td>
<td>42</td>
</tr>
<tr>
<td>1920-1939</td>
<td>25</td>
</tr>
<tr>
<td>Post-1939</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>145</strong>(1)</td>
</tr>
</tbody>
</table>

Source: RHB 64, Age of hospitals.

Note:
1. Information not available for all hospitals in the Newcastle RHB.

Table 6.3  Actual and intended size distribution of hospitals in the Newcastle RHB.

<table>
<thead>
<tr>
<th>Size (no. of beds)</th>
<th>At 31.12.60</th>
<th>Proposals for 1975</th>
<th>Long term proposals(1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 50</td>
<td>79</td>
<td>36</td>
<td>8</td>
</tr>
<tr>
<td>51-100</td>
<td>28</td>
<td>23</td>
<td>6</td>
</tr>
<tr>
<td>101-250</td>
<td>33</td>
<td>16</td>
<td>12</td>
</tr>
<tr>
<td>251-500</td>
<td>16</td>
<td>12</td>
<td>9</td>
</tr>
<tr>
<td>501-1000</td>
<td>4</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>&gt; 1000</td>
<td>-</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>160</strong></td>
<td><strong>98</strong></td>
<td><strong>49</strong></td>
</tr>
</tbody>
</table>

Source: Ministry of Health (1962)

Note:
1. These are strictly accurate only for the lower size ranges; in the two largest classes the precise figures for the distribution of beds between hospitals were not always given.
Figure 6.1: Hospital Facilities in the Newcastle RHB area in 1960
(see overleaf for inset)
Inset to figure 6.1 (see previous page)
Figure 6.2: Proposed pattern of hospital provision in the Newcastle RHB area in 1975.
6.3 **Issues in the implementation of the Plan**

This section provides a broad overview of the main shifts and/or changes of emphasis in hospital policy following 1962, with reference to developments in policy at national level and to the response to these by the Newcastle RHB. The outcomes of these policies are also examined, with reference to the use and distribution of capital investment and the number and distribution of hospital closures.

Shortly after the Plan's announcement it became clear that its full implementation would prove extremely difficult in view of the scale of public investment involved. Though there had been a marginal expansion of the Plan in 1963 (6.2), the Ministry of Health was concerned that if the building programme proceeded without delays, it would be impossible to finance all capital schemes from the resources available. Put another way:

'we sometimes have to delay target starting dates on financial rather than planning grounds'

(6.3)

In the context of the relatively slow growth of the British economy in the two years following the 1964 election, the scale of such expenditure commitments proved a burden for the Labour government. The relationship between public expenditure and the growth of the economy had become an issue of concern within six weeks of the return of Labour to power. In a bid to win votes before the 1964 election the Conservatives had announced major increases in public expenditure programmes. The incoming Labour government could not reduce these programmes drastically for fear of losing electoral support; on the other hand the government could not restore foreign confidence in the pound without such cuts (Crossman,
1976 (volume I), 80, 82-84; Brittan, 1969, 171-176). In relation to hospital building, the government therefore took a middle course, calling for a review of the Plan which stressed that development proposals should be related very closely to the level of resources likely to be available (6.4). The published revision of the Plan claimed that its initial aims had been over-optimistic and that many of the proposals were inadequately defined and imprecisely costed; consequently it was necessary to 'bring greater realism to hospital planning' and 'get the best possible value for the resources provided' (Ministry of Health, 1966, 1, 10). Stricter financial control was an explicit aim: the programme of developments was stated in terms of available finance rather than as a list of approved physical development schemes. Hence adjustments to the estimated cost of schemes would have to be made within the total sum approved for hospital development. In addition, Boards would not be able to allow for the effect of delays on their programmes (6.5). Thus, if a major development project was delayed, for whatever reason, the capital programme for subsequent years would not be expanded to allow for this. Hence the Newcastle RHB's concern at the effect of delays in the Freeman Road scheme on their long-term proposals for capital development (see chapter 10, below). The major features of the revised programme within the Newcastle RHB were that while the existing Plan had been preserved as far as possible the first priority had been given to schemes worth under £100,000 in order to provide for essential improvements at existing hospitals. As regards the allocation of resources within the Newcastle RHB, the needs of the three industrial estuaries
of the region were to be given the highest priority; in addition, the requirements of the rapidly-growing population of the Darlington area were to receive attention (6.6).

The overall effect of the 1966 revision was a slight slackening in the rate of growth of NHS capital expenditure (figure 6.3). Further attempts to rationalise hospital expenditure were made in the form of using standard-design units, but as these do not have any direct bearing on the spatial planning of facilities (except insofar as they had specific site requirements) they are not considered further (6.7). Instead, the proposals of the Bonham-Carter report (Central Health Services Council, 1969) are outlined; these influenced opinions on the scale (and hence spatial arrangement) of hospital services.

The intention of this report was to achieve the more economical and efficient use of medical manpower and to reap the benefits of scale economies in hospital construction. The report argued that DGHs:

'should be planned around teams of not less than two consultants in each speciality, with all their inpatients at the DGH'
(Central Health Services Council, 1969)

This partly reflected concern as to the future number of consultants likely to be available for the hospital service; the report had assumed that there were unlikely to be large increases in the number of such personnel, and therefore their efficient use was imperative. Such views were of considerable importance in the debate on the future organisation of acute hospital services in Newcastle (see chapters 8-10 below).

Though the assumptions concerning consultant availability subsequently proved groundless (6.8) the principal recommendation of the report - that DGHs should serve populations of
Figure 6.3: Growth of NHS capital expenditure, 1948-1978.

Note: Figures refer only to expenditure in England.
200-300 000 - caused considerable concern. Concentration of medical facilities into units of 1200-1800 beds followed logically from the report's contention that at least two consultants in each specialty should be available, but the social implications of such developments caused some alarm. Though the report had support within medical circles (6.9), the response of the DHSS and of the RHBs was less than enthusiastic. The Secretary of State's introduction to the report spoke of the needs of patients requiring long-term care and of the future role of peripheral hospitals, thus - by implication - arguing against the wholesale adoption of the report's recommendations. (Central Health Services Council, 1969, iv). Likewise, the RHB chairmen argued that these proposals 'ought not to be pursued in all situations' (6.10). Within the Newcastle RHB, the response was that developments in Newcastle, Sunderland and Teesside could be planned on the assumption that only two DGHs would now be necessary in each centre, rather than three as previously proposed (but see chapters 8-10). The populations of other HMCs (Gateshead, Darlington, S.E. Northumberland, S. Shields, Hartlepool and North Teesside) were large enough to permit the planning of hospitals to serve around 200,000 people. There remained the problem of the smaller HMCs. Both the Cumbrian HMCs would require DGHs because of their remoteness, but Wansbeck, Durham and the peripheral HMCs would have to rely heavily upon adjacent areas. Thus acute hospital services for Wansbeck would be provided from the DGH to be developed in S.E. Northumberland HMC. Finally, while it had never been the RHB's intention to provide full scale general hospitals in the Alnwick and Berwick HMCs, their proposals for 'peripheral' hospitals in Northallerton and Hexham caused some concern (see section 6.4). The effects of the Bonham-Carter Report on planning were
therefore felt most severely in the peripheral HMCs; the consequences in urban areas were rather less serious (6.11).

However, these recommendations were never formally adopted by the DHSS; a meeting of RHB chairmen recommended that the maximum size of hospitals should be of the order of 750-1100 beds (6.12); this seems to have been a response to the social implications of the implied concentration of services. Such a view was also echoed in a DHSS study which claimed that this size range was one in which hospitals functioned most efficiently (DHSS, 1972). Thus only in the Hexham and Northallerton HMCs did the Bonham-Carter Report lead to a questioning of former policy; in the rest of the Newcastle RHB the effect was marginal (6.13).

Following this report, no significant changes in policy on hospital size took place up to 1974. However, preliminary attempts were made to equalise resource distribution both between geographical areas and between sectors of the NHS, but as these are not of direct concern here they will not be discussed further (6.14). In any case, assessing the consequences of such proposals is rendered complicated not least by the effect on planning of the anticipated NHS reorganisation, but also by the 1973 public expenditure cuts. These had been imposed to reduce demand in the economy following rapid oil price rises; a reduction in GNP of 1½-2% was proposed, to be achieved largely by public expenditure cuts. A reduction of £47.8 million was imposed on the NHS capital building programme for England and Wales (House of Commons, 1974, viii), and although this was only a 20% reduction in the total building programme, it actually implied a 60% reduction in new starts, because the DHSS did not wish to interfere with or rephase existing contracts.
Moreover, new capital development had already been subject to a moratorium from September 1973, and the effect of this and the cuts was that no new NHS schemes were started between that date and March 1974 (House of Commons, 1974, viii-x). Within the Newcastle RHB this had led to the postponement of seven major schemes (6.15). These reductions brought to an end the rapid expansion of NHS capital expenditure, which had reached a peak in 1972-73 (figure 6.3).

The emphasis thus far has been on policy changes nationally, with brief reference to the implications of major developments - such as the 1966 revision of the Plan, and the Bonham-Carter Report - for local planning. The problems of local hospital development are now considered more closely.

While the Hospital Plan had initially been optimistic about the level of resources likely to be available for capital development, even to the extent of specifying proposals in the form of a list of physical development schemes, the 1966 revision was rather more guarded in tone (see above). In these circumstances, while HMCs were persistent in their demands for additional resources, RHBs had to proceed cautiously in response, though the government was reminded that restraint of and uncertainty about capital allocations was uneconomic in the long-term (House of Commons, 1970, 335-336). Thus the Newcastle RHB felt that deferment of schemes to which they were fully committed was a 'considerable embarrassment...which could cause a great deal of justifiable criticism' (6.16), not least because the declared policy of the RHB had been to develop services as evenly as possible throughout the region. Hence relatively small cost schemes had been undertaken in the
early years of the Plan (table 6.4), so that reductions in proposed expenditure would be likely to affect several projects and so generate criticism from more than one source. However the RHB conceded that their policy was disadvantageous in terms of temporary provisions, changes of use of facilities, the small size of building contracts, long gaps between successive phases of building at individual hospitals, and the need for continued expenditure on maintenance (6.17). An indication of the implications of such problems can be seen in figure 6.4. This gives the RHB's tentative programme of major capital developments and shows that (given certain assumptions about the capital resources likely to be available to the RHB) the DGH programme for the region could be completed by the end of the century. Even this target - which was considerably more optimistic than those of some RHBs, who were unlikely to complete their DGH programme in less than 50-60 years (6.18) - looks unrealistic in the light of subsequent developments. To take two examples, the commissioning of the Freeman Road Hospital, Newcastle, was seriously delayed by successive financial crises in the late 1970s (see chapters 7 and 10), while construction of Phase 1 of the new hospital for South East Northumberland (at Rake Lane, North Shields) did not commence until late 1980 - almost three years after the date indicated in figure 6.4. One final implication of the complications inherent in planning under these conditions was that the RHB were unable to commit themselves on the dates at which it might be possible to provide new facilities in some of the relatively deprived HMCs within the region - for instance, Sunderland and South East Northumberland (6.19). Against the background of these planning problems and policy
Table 6.4 Major schemes implemented by Newcastle RHB, 1962-1968.

<table>
<thead>
<tr>
<th>Scheme</th>
<th>Commencing Date</th>
<th>Value (£m)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shotley Bridge General Hospital, Phase I</td>
<td>April 1964</td>
<td>0.25</td>
</tr>
<tr>
<td>North Tees General Hospital, Phase I</td>
<td>August 1965</td>
<td>2.00</td>
</tr>
<tr>
<td>Darlington Memorial Hospital, Phase I</td>
<td>October 1965</td>
<td>2.00</td>
</tr>
<tr>
<td>Queen Elizabeth Hospital, Gateshead, Phase I</td>
<td>November 1965</td>
<td>0.50</td>
</tr>
<tr>
<td>Bishop Auckland General Hospital, Phase I</td>
<td>August 1966</td>
<td>0.50</td>
</tr>
<tr>
<td>South Shields General Hospital, Phase I</td>
<td>October 1966</td>
<td>0.50</td>
</tr>
<tr>
<td>Ashington Hospital, Final Phase</td>
<td>September 1967</td>
<td>0.50</td>
</tr>
</tbody>
</table>

Source:
Newcastle RHB, Evidence to Sub Committee B of the Select Committee on Estimates, 1969 - held in RHB 145/2/K/9.
<table>
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</tr>
</thead>
<tbody>
<tr>
<td>Newcastle (Freeman)</td>
<td>1 (7.5)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Newcastle (General)</td>
<td>1 (3.7)</td>
<td>2 (1.0)</td>
<td>3 (1.9)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gateshead (Queen Elizabeth)</td>
<td></td>
<td>2 (0.9)</td>
<td>3 (2.3)</td>
<td>4 (1.8)</td>
<td>5 (1.9)</td>
</tr>
<tr>
<td>S Shields (General)</td>
<td>2 (0.9)</td>
<td>3 (3.0)</td>
<td>4 (1.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S E Northumberland (new hosp.)</td>
<td></td>
<td>1 (2.0)</td>
<td>2 (3.0)</td>
<td>3 (3.0)</td>
<td></td>
</tr>
<tr>
<td>Hexham (General)</td>
<td></td>
<td>1 (1.0)</td>
<td>2 (2.0)</td>
<td>3 (3.0)</td>
<td></td>
</tr>
<tr>
<td>Wansbeck (Ashington)</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Wansbeck (new hosp.)</td>
<td></td>
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<tr>
<td>NWDurham (Shotley Bridge)</td>
<td></td>
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<tr>
<td>Sunderland (General)</td>
<td>1 (1.5)</td>
<td>2 (2.9)</td>
<td>3 (2.0)</td>
<td>4 (2.0)</td>
<td></td>
</tr>
<tr>
<td>Sunderland (3rd DGH)</td>
<td></td>
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<tr>
<td>Sunderland (Ryhope)</td>
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<tr>
<td>Hartlepool (General)</td>
<td>2 (4.9)</td>
<td>3 (2.0)</td>
<td>4 (1.5)</td>
<td></td>
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</tr>
<tr>
<td>N Tees (General)</td>
<td>1 (1.0)</td>
<td>2 (2.0)</td>
<td>3 (2.0)</td>
<td>4 (1.0)</td>
<td>5 (1.0)</td>
</tr>
<tr>
<td>S Tees (General)</td>
<td></td>
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<tr>
<td>S Tees (Kirkleatham)</td>
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<td></td>
</tr>
<tr>
<td>SW Durham (Bishop Auckland)</td>
<td>2 (1.0)</td>
<td>3 (1.4)</td>
<td>4 (1.5)</td>
<td>5 (0.4)</td>
<td>6 (0.9)</td>
</tr>
<tr>
<td>Durham (new hosp.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Darlington (Memorial)</td>
<td>2 (5.1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Northallerton (Friargate)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E Cumbns. (Infirmary)</td>
<td>1 (2.0)</td>
<td>2 (3.2)</td>
<td>3 (0.9)</td>
<td>4 (1.8)</td>
<td>5 (0.5)</td>
</tr>
<tr>
<td>W Cumbns. (W Cumberland Hosp.)</td>
<td></td>
<td></td>
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</tbody>
</table>

Note: Figures refer to phase of development, with cost (£000 000 pounds) in brackets

Figure 6.4: Progress of major capital schemes in the Newcastle RHB

Source: Newcastle RHB, Unpublished Paper (1968)
changes, it is instructive to analyse three issues, namely: the growth of capital investment and the use to which it was put, both locally and nationally; the intra-regional allocation of capital resources; and the number and distribution of hospital closures.

Figure 6.3 (see above) shows that capital expenditure rose rapidly for the first two years of the Plan, but its growth then slackened slightly in the term of office of the Labour government in the late 1960s; after increasing again in the early 1970s, the 1973 cuts represented the first setback to the expansion of the Plan. This period also witnessed an overall expansion in the proportion of NHS resources used for capital expenditure (figure 6.5); this reached a peak of 12% in 1972-1973. The reductions in the late 1960s represent not only restraint on the Plan's implementation, but also attempts to switch resources from capital to revenue accounts in order to improve conditions in the long-stay and mental hospitals, revelations about which provoked a public outcry (6.20). In terms of the use of NHS capital expenditure in 1962-1974, between 22.7% and 39.7% was used in new hospital construction (figure 6.6). By contrast the corresponding proportion in the Newcastle RHB was rather lower throughout this period, with the exception of 1961-1962 and 1973-1974 (figure 6.7). The high figure for 1961-1962 was due almost entirely to a large investment in the new West Cumberland Hospital in that year. The relatively low proportion of capital devoted to new construction reflected the RHB's policy of attempting to spread its resources as evenly as possible, rather than concentrate on a few major projects (6.21).

Notwithstanding this policy intention, it is nevertheless
Figure 6.5: Proportion of NHS resources used for capital expenditure, 1948-1981.

Source: Ministry of Health/DHSS - Summarised Accounts of Health Authorities
New Hospital Construction
Medical Service/Outpatients Depts.
Ward Accommodation
Ancillary Depts./Engineering Works
Fees/Salaries/Wages
Staff Quarters/Amenities
RHB Schemes
Administrative Offices

Figure 6.6: Use of NHS capital resources in England and Wales 1962-1974.

Source: Ministry of Health - Summarised Accounts of Health Authorities

Share of Capital Expenditure (%)
Figure 6.7: Use of capital by Newcastle RHB, 1962-1974.

Source: Newcastle RHB Annual Accounts
clear that - intra-regionally - capital development was uneven, a result of the constraints discussed above and of the difficulties of agreeing on local strategies for future development. Considering the per capita distribution of the RHB's capital expenditure (refer back to figure 5.6), it is clear that the most favoured area in this period was Teesside. As noted above, this had become one of the RHBs top priorities for capital development in the 1950s, and this can plausibly be linked to the importance attached to industrial development there by various state planning agencies (see chapter 5). By contrast, the peripheral rural HMCs were less favoured (e.g. Alnwick and Rothbury, Berwick, South West Durham); investment was limited to minor schemes at the relatively small hospitals in these HMCs, since the RHB did not intend to provide full DGH facilities in such areas. The lowest per capita investment in this period was in South East Northumberland HMC; this represented something of an 'inverse care' situation, for despite the recognition of the Hospital Surveyors that major developments were necessary in this area, (Ministry of Health, 1946 (volume 10), 96), investment in this HMC had been persistently low relative to the rest of the region since 1948.

Finally, the Plan's aims in terms of hospital closures proved over-optimistic. Progress of closures was uneven, reaching a peak of 39 in 1968 (table 6.5) (in England; data not available for Wales). The Newcastle RHB was scheduled to close 41 hospitals by 1975 but only 14 closures had been effected by 1974 (figure 6.8). This reflects the problems both of implementing the Plan and of obtaining agreement on local hospital strategy.

To conclude, this section has described the major shifts
Table 6.5 Hospital closures and change of use in England, 1962-1969.

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<td>1</td>
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<td>.6</td>
<td>12</td>
<td>15</td>
<td>13</td>
<td>52</td>
</tr>
<tr>
<td></td>
<td>Reorganisation</td>
<td>14</td>
<td>16</td>
<td>5</td>
<td>11</td>
<td>13</td>
<td>9</td>
<td>24</td>
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<td>17</td>
<td>6</td>
<td>14</td>
<td>19</td>
<td>21</td>
<td>39</td>
<td>38</td>
<td>179</td>
</tr>
<tr>
<td>Change of Use</td>
<td>New provision</td>
<td>-</td>
<td>-</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Reorganisation</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>4</td>
<td>2</td>
<td>7</td>
<td>7</td>
<td>2</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>-</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td>9</td>
<td>10</td>
<td>6</td>
<td>38</td>
</tr>
<tr>
<td>Closure &amp; change of use</td>
<td>New provision</td>
<td>-</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>6</td>
<td>14</td>
<td>18</td>
<td>17</td>
<td>64</td>
</tr>
<tr>
<td></td>
<td>Reorganisation</td>
<td>14</td>
<td>18</td>
<td>5</td>
<td>15</td>
<td>15</td>
<td>16</td>
<td>31</td>
<td>27</td>
<td>153</td>
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<tr>
<td></td>
<td>Total</td>
<td>14</td>
<td>19</td>
<td>9</td>
<td>18</td>
<td>21</td>
<td>30</td>
<td>49</td>
<td>44</td>
<td>217</td>
</tr>
</tbody>
</table>

Source: Newcastle RHB: Unpublished papers held in RHB 43.
Figure 6.8: Actual and proposed hospital closures in the Newcastle RHB, 1962-1974.

in policy which followed the announcement of the Plan; secondly, the problems of planning have been outlined within this broad context; and finally, the specific changes which occurred during this period have been examined. Several factors combined to restrict the extent to which it proved possible to implement the Plan. Public expenditure restraint was perhaps the most important factor; such restraint has seriously limited the ability of RHBs to make progress with the long-term development of their services and to respond to social need. Hence, by 1974, the Plan was already falling short of its targets. Two further problems should also be considered, however; these are the social implications of such a concentration of services, and the problems of responding to the needs of areas of rapid population change, particularly at the sub-regional scale, and these are considered in the next section.

6.4 **Social and political problems in hospital planning.**

This is a somewhat broad issue and so only two key themes are discussed. Firstly, the problems of achieving the requisite number of closures proposed by the Plan will be discussed; related to this, the social costs of service concentration will be considered. Secondly, attention is directed to the difficulties of responding to localised population change. These themes are important illustrations of the extent to which the state is able to implement its declared intentions.

While the relatively slow progress in implementing the Plan reflects uncertainties as to the availability of capital resources, this is only a partial account, because the Plan's implementation was also subject to agreement being reached on closure proposals. The DHSS felt that opposition to closures
would cease once the public accepted that a spatial concentration of facilities was in everyone's best interests, due to the superior service that would be provided (6.22). In practice, considerable resistance developed to hospital closures. Under the terms of the 1946 NHS Act, the Minister of Health was obliged to ensure that hospital buildings were, as far as possible, used for the purposes for which they had been employed immediately prior to the setting up of the NHS. In these terms, communities evidently had a right to anticipate the retention of their local hospital unless this was totally impracticable (for instance, if the physical condition of the building was no longer adequate for the provision of hospital facilities) and the arrangements for consultation on closures or changes of use emphasised this Ministerial obligation (6.23).

However, a different emphasis emerged in policy from 1968; RHBs were:

'actively encourage(d) to promote closures and change of use of uneconomic units as an essential measure to facilitate the provision of a planned service' (6.24).

Yet even this, which explicitly promised Ministerial support for closure proposals, had been of limited practical value. RHB chairmen commented on the grave difficulties of implementing closures; even tentative proposals provoked a public outcry, while early consultation ensured that agitation was greatly prolonged. In addition, Boards complained that:

'the support of ministers for closure proposals... is... never speedily given and seldom unequivocal' (6.25).

The latter point may reflect direct political pressure on ministers, on the part of constituency MPs, but this cannot be substantiated from the available evidence (6.26). In response to such problems, RHBs argued that closures and
change of use should be dealt with 'by a running-down process' which would commence once alternative provision was available, rather than in advance of the provision of new hospitals (6.27). Thus, faced with pressures for the retention of services, it may well be that RHBs refrained from the full implementation of the Hospital Plan.

The social consequences of hospital closures were felt most acutely in rural areas. As was observed in Parliament, it was an 'unhappy coincidence' that the Plan was announced:

'at the moment when the Minister of Transport is busy dismantling rural transport services by both rail and road' (6.28).

The implied accessibility problems were causing concern shortly after the Plan's announcement. Thus the Newcastle RHB reassured various local institutions that their aim was not an excessive centralisation; rather, small units would be retained in some local centres (Alston, Penrith, Alnwick, Rothbury) and additional facilities would be provided in places not already possessing them (e.g. Millom, Kirkby Stephen) (6.29). On the grounds of economies of scale, the Board were unwilling to consider a scattering of acute hospital facilities, but local hospitals would be retained for the reception and treatment of 'social cases' (6.30). However, following the publication of the Bonham-Carter Report, there developed considerable local opposition to the RHB's proposals, particularly in the case of Northallerton which could not support a DGH along the lines indicated in the Report. Consequently the RHB envisaged running down the existing Friarage Hospital in Northallerton, according it the status of a 'peripheral' hospital (6.31). This generated a fierce protest, orchestrated by several local authorities and voluntary agencies (6.32), and
articulated in local newspapers (6.33). As discussed above, the Bonham-Carter Report's recommendations were never implemented fully, but one consequence of such responses to it was a move towards providing community hospitals to serve rural areas. Pilot schemes for such facilities had already been experimented with by the Oxford RHB (see House of Commons, 1970, 377-386), and they were subsequently adopted as a policy option in 1974.

Thus the ability of RHBs to implement the Hospital Plan in full was constrained not only by uncertain capital allocations but also by the political difficulties of gaining both public assent and Ministerial consent to closure proposals. This necessitated both a firmer line on closures and also concessions to those areas likely to suffer most from service concentration. But if RHBs were constrained by several social and political factors in the extent to which they could implement hospital closures, they were also seriously hampered in terms of responding to the needs of areas of rapid population change - particularly new towns.

There existed serious problems of integrating the growth of new towns with health service planning. Given the 'threshold' populations required for full-scale DGH development - at least 100-150 000 - it was unlikely that new towns would merit consideration for development on this scale, except where their target populations exceeded this figure (for instance Milton Keynes - see Parston, 1980). Nevertheless, NTDCs were persistent in their demands for hospital services appropriate to the needs of their population, but at least two problems were encountered.

Firstly, there was the uncertainty of population growth
in new towns. NTDCs made various predictions as to the anticipated ultimate size of their towns - that of Washington, for example, was 80,000 (Llewelyn-Davies et al., 1966), but they could not guarantee that these targets would be achieved. This depended partly upon overspill agreements and partly upon voluntary migration.

Secondly, site availability was to prove a general problem for hospital planners following the announcement of the Plan, because of the acreage required for DGH development. A spokesman for one of the Metropolitan RHBs claimed that, once local authorities ceased to be responsible for hospital provision in 1948,'hospitals went to the bottom of the queue for land requirements' (House of Commons, 1970, 338). RHBs were constrained by public expenditure decisions to such an extent that they could not guarantee when they were likely to be able to build a hospital; hence NTDCs were unwilling to 'sterilise' large areas of land. Consequently, various experimental and/or hybrid schemes for health service provision were put forward; in particular, the new town environment offered an opportunity to combine health centres, for instance, with hospital outpatient facilities (see Dillane, 1966; Draper et al., 1971; Parston, 1980; Reid and Gooding, 1975; Sichel, 1969 a,b; 1970). Yet such schemes were not always successful, sometimes meeting medical opposition to their proposals; moreover, the complexities of coordinating the intentions and practices of RHBs and NTDCs often rendered the development of an agreed strategy a drawn-out and long-term process. Clearly, therefore, there existed constraints on the ability of RHBs to respond to the perceived needs of new towns. At one level this might be seen as a purely technical problem, to be resolved by more sophisticated sub-regional resource allocation procedures. However,
it seems that problems of coordinating the intentions of various state agencies, and of guaranteeing (for instance) land availability, appear to be of more decisive influence; this will be illustrated by a discussion of hospital planning for Peterlee and Washington (Chapter 8).

6.5 Concluding comments

The aim of this chapter has been to consider issues in the implementation of the Hospital Plan from 1962-1974, at national level and within the Newcastle RHB. Two sets of factors influenced the extent to which the Plan was put into operation.

Firstly, there existed a variety of constraints upon the volume of resources available for the Plan. At the level of central government this was reflected in Cabinet debates about the economic measures necessary to restore foreign confidence in the pound. In turn these led to calls for a rationalisation of the public sector, illustrated by the 1966 review of the Plan, the non-adoption of the Bonham-Carter Report, and the search for standard-design, hospital units. Local hospital planning therefore, had to proceed in what was, at best, an uncertain environment; this in turn constrained the ability of RHBs to respond to social need for hospital provision.

Secondly, there existed socio-political constraints upon the ability of the state to implement the Plan. These arose from the proposed concentration of hospital services, protests against which became especially marked at the time of the Bonham-Carter Report. Two policy changes resulted: one of these - an attempt to pursue a firmer closure policy - was intended to facilitate the Plan's full and rapid implementation, while the other - the community hospital concept - can be seen
as an attempt to draw back from and/or avoid the less palatable social consequences of the Plan. Though they have not been discussed in detail above, the implementation of the Plan has also been hindered by disputes over hospital strategy at the local scale (see Chapters 8 to 10). Finally, for various reasons - notably conflict over land use allocation, opposition on the part of medical professionals, and uncertainty over population growth - the ability of RHBs to develop hospital services appropriate to the needs of new towns was very limited. What are the implications of the foregoing for theorising the role of the state?

Firstly, the view of state policy formulation as a strategy of crisis avoidance (Offe, 1976, 415) seems a particularly apposite characterisation of some of the policy changes discussed here. Perhaps the best illustrations of this would be the 1966 revision of the Plan, and the public expenditure cuts in late 1973, though the apparent reluctance of the Government to implement in full the proposals of the Bonham-Carter Report may also be construed as an attempt to avoid the public expenditure implications and the social consequences of such plans.

Secondly, the ability of the state effectively to implement its declared intentions appears to be called into question by the foregoing evidence. The socio-political and economic constraints that restrict the scope of state activities both serve to pose the problem of the limits to state intervention, and to produce a divergence between the stated intentions and actual outcomes of state policies, revealed by delays in the progress of the Hospital Plan.

Thirdly, given that there exist various demands upon the
state, it has been argued that policy formulation proceeds in a selective fashion (Offe, 1974), favouring those groups whose support is deemed essential to the existing social order. This is evident, for example, in the way the medical profession's requirements became manifest in the Bonham-Carter Report; though never formally adopted, this Report 'influenced thinking on the size of hospitals in an upward direction' (DHSS, 1979b, 83), reflecting the influence of the medical profession in terms of defining the character - and, by implication, spatial arrangement - of hospital provision. Yet if certain groups are selectively favoured, it also follows that certain aspects of state policies receive relatively less attention. Thus the limited consideration given to the access implications of DGH development is evidence that, when efficient management is deemed essential, a concern for social costs tends to be sacrificed. These accessibility problems therefore had to be justified as necessary by reference to the better quality of service which would be provided. The foregoing evidence therefore illustrates the selective character of state policy formulation and shows that it is most appropriately understood as a strategy of crisis avoidance, to which there are, however, various limits. The problems of hospital planning were to be posed rather more acutely, however, by several developments in the 1970s, and these are considered in the next chapter.
6.1 This topic has not been considered due to data problems. The Ministry of Health Annual Accounts and Annual Reports do not contain a regional disaggregation of the distribution of capital investment. The statistics available in Regional Trends only refer to Standard Regions before 1974; these areas are not coterminous with RHBs. Though there exists DHSS data on the number and size distributions of hospitals in each RHB from 1970, this does not permit comparison of closures since this data does not state (a) how many new hospitals had been built in each RHB and (b) how many closures had taken place. Hence any estimate of closures arrived at by subtracting the number of facilities available in - say - 1974 from those available in 1962, is likely to be inaccurate.

6.2 This expansion occurred in April 1963; four major schemes were added to the Newcastle RHB's programme. These included major developments at Newcastle General, Queen Elizabeth, and South Shields General Hospitals (as well as modernisation of accommodation at one psychiatric institution)- RHB Press Release 9.4.63, held in RHB 145/2/H.

6.3 Letter from the Ministry of Health to the Secretary of Liverpool RHB, 22.9.64 - copy held in RHB 145/D.

6.4 HM(65)37, Review of the Hospital Building Programme.

6.5 Newcastle RHB, Review of the Hospital Plan and the Ten Year Capital Programme, October 1965 - held in RHB 145/2/H.

6.6 Ibid.

6.7 Interest in standardisation of hospital design and construction can be traced at least to the Ministry of Health's Hospital Building Notes, dating from 1961. The first attempt to introduce standard units and to reduce construction and site development costs was the development of Eastburn Hospital, in the Leeds RHB (see Ham, 1981, 65-67). This was the forerunner of various attempts to standardise hospital development, such as the 'Best Buy' hospitals at Bury St. Edmonds and Frimley (House of Commons, 1970, 23-24).

6.8 Newcastle RHB - Policy following the Bonham-Carter Report (n.d. - probably early 1970) - held in RHB 43.

6.9 Local support for the Report's recommendations was evident in, for example, the views of Henry Miller, an influential figure in the Freeman Road dispute (see Chapter 10), who argued for hospitals of around 2,000 beds (Miller, 1973).

6.11 Newcastle RHB - Functions of the District General Hospital: Report of the Senior Administrative Medical Officer and Secretary - held in RHB 145/44.


6.13 Newcastle RHB - File note on modifications of hospital plans since Cmnd. 3000, October 1970 - held in RHB 145/2/H.

6.14 Despite the conditions of the mental and long-stay hospitals at the inception of the NHS, little was done to alleviate this problem (apart from a priority allocation of capital resources to mental hospitals in the mid 1950s) until 1969. Following a report on conditions at Ely Hospital, Cardiff, some efforts were made to reallocate resources to long-stay services. As for resource allocation in the acute sector, the population-based estimates of the Hospital Plan were supplanted by a more sophisticated assessment (which also considered hospital workload and the condition of the capital stock) from late 1969. On these developments see Crossman, (1976 (volume III), various entries).

6.15 Newcastle RHB - Hospital Services Development Committee meeting, 4.2.74 - notes held in RHB 145/44. The affected schemes included developments at Sunderland General Hospital, South Shields General Hospital, Cumberland Infirmary, North Tees General Hospital, and the City Maternity Hospital, Carlisle (as well as two projects at mental hospitals).

6.16 Letter from the Newcastle RHB to the Ministry of Health, 11.1.65 - copy held in RHB 145/2/Q/10.

6.17 Newcastle RHB - memorandum of evidence to the House of Commons Select Committee on Estimates: Sub-Committee B (the Hospital Building Programme) - copy held in RHB 145/2/K/9.

6.18 Report of a meeting between officers of RHBs and the Ministry of Health, 30.6.68 - copy held in RHB 145/2/H.

6.19 Internal memorandum on the RHB's capital programmes 14.12.67 - held in RHB 145/2/H.

6.21 Newcastle RHB - memorandum of evidence to the House of Commons Select Committee on Estimates - held in RHB 145/2/K/9.

6.22 DHSS evidence to sub-committee B of the House of Commons Select Committee on Estimates inquiry into the Hospital Building Programme - copy held in RHB 145/2/K/9.

6.23 RHB (49) 132 and HM (58) 29 gave details of appropriate consultation procedures.

6.24 HM (68) 31.

6.25 Paper on closures and changes of use of hospitals, prepared for a meeting of RHB chairmen, October 1970 - copy held in RHB 43.

6.26 There is evidence from Richard Crossman's Diaries that a Cabinet decision to maintain subsidies for the Central Wales railway line (and so avoid its closure) was taken largely in anticipation of the possibility that Labour seats might be at risk in that area (see Crossman, 1976 (volume III), 602-603). Such evidence is unlikely to be forthcoming at government level in the case of hospitals, given that decisions on the closure of individual facilities are usually taken at regional level. However, it is interesting to note a reference to such issues in Barbara Castle's Diaries (1980, 601). Defending the hospital building programme in Cabinet, she deliberately referred to the possibility of delays in the construction of new hospitals in the constituencies of certain Cabinet members.

6.27 Paper on closures and changes of use of hospitals, prepared for a meeting of RHB chairmen, October 1970 - copy held in RHB 43.

6.28 Kenneth Robinson, H.C. Deb., 661, c.51, 4.6.62.

6.29 Letter from the RHB to Alderman Robson (of Prudhoe) concerning hospitals in rural areas, 22.4.63. - copy held in RHB 145/2/H.

6.30 Minutes of a meeting of the RHB's capital development sub-committee, 3.5.63 - extract held in RHB 145/2/H.


6.32 RHB 145/44 contains correspondence from Northallerton RDC (10.2.70), Northallerton UDC (21.1.70), North Riding County Council (20.2.70), Northallerton HMC (17.2.70) and the Friends of Darlington Hospitals (6.2.70).
RHB 145/44 also contains press cuttings reporting opposition to this development from, variously, the Northern Echo (14.1.70, 16.1.70, 24.1.70), the Middlesbrough Evening Gazette (8.1.70), the Darlington and Stockton Times (17.1.70) and the Yorkshire Post (17.1.70). Such responses were by no means confined to the Newcastle RHB, as the experience of the Leeds RHB testifies (see Ham, 1981, 68).

7.1 Introduction

The previous chapter discussed some important issues in the implementation of the Hospital Plan, up to the 1974 NHS reorganisation (see Appendix I for details of NHS administrative structures). This chapter now considers events in the subsequent eight years. Though this might seem an arbitrary periodisation, important continuities exist between Labour and Conservative governments in terms of their attitudes to public expenditure, and these are discussed in section 7.2; the implications of such policies for NHS planning are also examined. Because of limitations of space and the complexity of the issues to be discussed, a full account of developments in the Northern RHA is not presented. Rather, events in Newcastle AHA(T) are used to exemplify the implications of expenditure restraint for hospital development. Although closures of certain facilities had been foreshadowed in the 1962 Hospital Plan, the timing of these closures and the manner of their making represented a response to various financial crises (section 7.3). The recent developments in hospital policy are then considered (section 7.4); their implications for the Northern RHA are noted, and current policy guidance is contrasted with the original intentions of the Hospital Plan.

7.2 Public expenditure restraint and NHS planning, 1974-1982.

This section discusses the important consistencies in attitudes to public expenditure between Labour (1974-1979)
and Conservative (1979 to date) governments, and outlines their implications for NHS planning. In general, this period has been characterised by a view that public expenditure represents a burden on private capital, and should therefore be reduced or at least tightly controlled. The reasons for the emergence of such views are not analysed here (see, inter alia, CSE State Group, 1979; Doyal, 1979; Gamble, 1979; Gough, 1979; Manson, 1980; Taylor-Gooby, 1981; Walker, 1980). Rather, attention is directed to attempts to reduce or restrain public expenditure, and to policies designed to rationalise, restructure and gain firmer control of public expenditure.

Attempts to reduce or restrain state expenditure during this period can be traced not simply to the demands of the IMF in late 1976 but rather to the increased pace of inflation in 1974-1975. From early 1976 it was clear that the government intended to reduce the share of public expenditure in GNP and this was a persistent feature of subsequent Labour budgets (Ormerod, 1980, 51). Several reductions in public expenditure (in February, April, July and December 1976) followed. That these posed serious problems for strategic planning is graphically revealed by the following quote; discussing the Cabinet debates on the April 1976 cuts, Barbara Castle (7.1) complained that:

'Ministers were never given the chance of discussing priorities or overall economic strategy. Instead we were faced with ad hoc demands from the Chancellor from time to time, pleading sudden crisis or necessity. How could I get my health authorities to plan the NHS properly when the capital allocations were abruptly changed?'

(Castle, 1980, 359-360 — emphases added)

Under such circumstances, any attempt at long-term planning was doomed to failure. The NHS capital building programme was
particularly hard hit by such reductions, and new construction suffered most of all, since it was considered essential to maintain the on-going capital programme. Yet in the absence of new developments, additional expenditure was necessary to modernise existing facilities. Thus postponements of capital projects in the Gateshead and North Tyneside AHAs necessitated extending the lifespan of some old hospitals, at least one of which - the Preston hospital (North Shields) - had been recommended for closure in the Hospital Survey (7.2). Such postponements were seen as preferable to building a new hospital and being unable to open it due to lack of revenue funds. Moreover there may have been electoral pressures to cut new capital expenditure. Since such reductions applied to services that, by definition, had not been provided, their implementation was 'electorally slightly less disadvantageous than cutting on current expenditure' (House of Commons, 1977, 103, 105-107; Pliatzky, 1982, 147-161).

Attempts to restrain and/or reduce public expenditure by the Labour government thus appear as ad hoc responses to crises rather than as a systematic pursuit of stated objectives. In contrast, the policy of the Conservative government was explicitly stated. Though in principle committed to maintaining the level of resources available to the NHS, their attitude was that public expenditure was totally dependent on national economic performance:

'Higher public expenditure cannot any longer be allowed to precede, and thus prevent, growth in the private sector'.

(House of Commons, 1979, 2).
The implications for public expenditure are that:

'it is simply a question of tailoring the whole budget to what we can afford and to what is consistent with the rest of the government's economic policy'.

(House of Commons, 1980, 85 - emphasis added)

The implications of such policies will receive detailed discussion below, with reference to events in Newcastle AHA (T). Thus the difference between the policies of Labour and Conservative governments is principally that the expenditure reductions imposed by the former represented ad hoc responses to crises, whereas the latter have attempted more systematically to control the share of state expenditure in GNP.

Secondly, several attempts were made to rationalise and restructure state expenditure. In the first major reform of public expenditure control since the introduction (in 1961) of the PESC system, cash limits on public expenditure were introduced in 1976. The NHS is an obvious candidate for such controls since several factors, including demographic pressure, the absence of financial barriers to use of services (Powell, 1975) and the labour-intensive character of the service (Manson, 1980), all combine to produce persistent upward pressure on costs. Cash limits were initially intended to guarantee firmer control of expenditure without reducing the volume of services, but the attainment of cash limit targets has increasingly taken precedence over maintenance of planned volumes of service. In this respect, considerable continuity exists between Labour and Conservative governments (House of Commons, 1980, ix), though the latter have stressed more forcefully the need to achieve cash limit targets. Consider the following:

'(cash limits)are paramount once the year starts...
they take precedence over the volume, ... and that is why we have the phenomenon called squeeze... once set, it (a cash limit) must stay set, and if anything has to give, it is the volume'.

(House of Commons, 1980, 23 - emphasis added).

It is worth noting that although local planning problems have resulted from such policies (see section 7.3 below), and although such problems can be traced directly to the effects of government fiscal policy, responsibility for these problems is devolved explicitly to the local tiers of NHS administration. Thus if service reductions were necessary a DHSS official claimed that:

'we would not direct in detail where the cuts should fall since the management of the service can only be conducted at the front line where the troops and tanks are'

(House of Commons, 1980, 33)

This is consistent with the emphasis in government policy upon local autonomy and flexibility in planning (DHSS, 1979a; 1980a; see also section 7.4). However, it could be taken as a disturbing indication of an unwillingness, on the part of central government, to accept responsibility for the consequences of its own fiscal policies. In exceptional circumstances indeed, the effect of resource redistribution and cash limit policies has provoked direct challenges from health authorities to central government, though this has not occurred within the Northern RHA (7.3).

Restructuring of NHS expenditure has also been attempted by the introduction of formal planning procedures (DHSS, 1976a) and more clearly defined criteria for resource allocation between sectors of the NHS (DHSS, 1976b; see also Rathwell, 1980) and between geographical areas (DHSS, 1976c). The latter, in particular, has had serious implications for
hospital planning, especially in the London area (Community Health Councils in London, 1980; NUPE, 1979; London Health Planning Consortium, 1979; 1980; Woods, 1982). It ignores the problems of subregional resource allocation which result from wide intra-regional disparities in social conditions and in availability and quality of services (Buxton and Klein, 1978; DHSS, 1980b; Bevan and Spencer, 1982; Eyles, Smith and Woods, 1982; Radical Statistics Health Group, 1977). For example, in the Northern RHA, where variability in service availability between AHAs was — relatively speaking — not a serious problem, there remained health districts in which total renewal of the capital stock would be necessary (7.4). Irrespective of the serious problems inherent in developing NHS resource allocation procedures, it is worth noting, finally, that one of the practical effects of the RAWP proposals has been to divide health authorities against one another. Debate on its proposals has therefore consisted less of attacks on their merits than of special pleading on behalf of particular areas (7.5).

Thus the Labour government made various attempts to secure tighter control of resource allocation decisions within the NHS. These policies have, broadly speaking, been maintained since 1979, though there has been a shift in emphasis, evident not only in attitudes to cash limits but also in a questioning of the value of state expenditure. One policy response has been the latest NHS reorganisation (DHSS, 1979a); there has also been a search for clearer indicators of NHS 'performance', exemplified in the evidence of various Select Committees (House of Commons, 1980; 1981; 1982; see also Klein, 1982).

Thus several important continuities existed between Labour and Conservative administrations, in terms of their attitudes
to state expenditure, though this is not to deny differences in emphasis in their policies. The two governments differ more fundamentally in their attitude to the appropriate balance between state and non-state provision of health care. Thus the development of private hospitals (documented by NHS Unlimited, 1982) follows logically from current policy emphases on the virtues of consumer choice and a market allocation of resources (see, inter alia, Adam Smith Institute, 1981; Seldon, 1981). It should not be forgotten, however, that the growth of independent hospitals was, at least initially, an unintended consequence of Labour's attempts to restrain private practice in the NHS (Knight, 1979; Politics of Health Group, 1981). Emphases on the importance of voluntary and community support for health services also represent a new departure in health policy since 1979; thus recent guidelines advocate a transfer of resources and patients out of long-stay NHS facilities and into the community (DHSS, 1981).

In conclusion, this section has examined the changes in government policy towards public expenditure and the NHS in 1974-1982, and has stressed the important continuities in policy between the Labour and Conservative governments. As explained above (section 7.1) a complete account is not presented of the implications of these policies for the whole of the Northern RHA. Instead, events in Newcastle AHA(T) are used to exemplify the implications of public expenditure restraint for hospital development.

7.3 Hospital planning in Newcastle AHA(T), 1974-1982.

Investigation of hospital planning in this area can be justified on three counts. It is a large urban area with a variety of social and economic problems; acute hospital
services are spread between three sites, posing serious planning problems; and the need to commission the new Freeman Road hospital has been a major constraint on the Authority's operations. The facilities taken over by Newcastle AHA (T) in 1974 are shown in figure 7.1. Two points should be borne in mind in considering subsequent events. Although the closure of several hospitals had been proposed in the Hospital Plan (Ministry of Health, 1962, 17-19), at issue here is the way in which some closures came about. Secondly, there exist some problems of evidence in that no clear statement of the Authority's intentions was available prior to the publication (in 1977) of their first Strategic Plan (Newcastle AHA (T), 1977) though occasional references in the Authority's minutes partly close this gap.

The AHA (T) inherited a situation in which certain on-going capital developments were likely severely to limit their scope for manoeuvre. Thus the commissioning of Freeman Road hospital was seen as a 'conditioning factor' (7.6) by the Authority. Other capital projects - a new Ward Block at the RVI, and the new Dental School - would also create intensive pressures on the AHA (T)'s resources, and the expansion of the University Medical School would necessitate rapid progress in the redevelopment of the RVI (Newcastle AHA (T), 1977, 10). Against this background, the Authority sought to close certain peripheral hospital units, namely the Walker Park, Sanderson, Fleming and Babies' Hospitals (see figure 7.1). Thus the AHA(T) emphasised the difficulties of retaining the specialist facilities of the Fleming Children's Hospital; it was not worth upgrading or reproviding services on a constricted and - in relation to the rest of the city's hospitals - isolated site
Figure 7.1: Hospitals taken over by Newcastle AIAT(T), 1974.

Source: Newcastle RHB Annual Accounts
The initial impetus for the closure of the Walker Park and Babies' hospitals can be traced to the effects of financial stringency in late 1976. In attempting to avoid closures, the AHA(T) had considered overspending, but came down in favour of balancing its books in the first year of the operation of cash limits (7.8). The Walker Park closure, though initially temporary, was subsequently made permanent (7.9). Though the Fleming Hospital remains open, its future is uncertain (see below). Apart from the service reductions imposed late in 1976, which also included ward closures at the RVI and the General Hospital (NGH), the Authority successfully contained expenditure within £5 cash limits in the late 1970s (7.10).

However, the AHA(T)'s financial position deteriorated from mid-1979. An increase in VAT from 8% to 15%, combined with inflation running at 16% - 17%, was likely to cost the Authority some £0.5 million in 1979-1980; this burden was 'the direct result of the government's fiscal policy' (7.11). Moreover, the cost of wage settlements greatly exceeded the assumptions on which DHSS planning had been based; the NHS was expected to bear the first £22 million of the excess cost. The sum involved in Newcastle AHA(T) - £279,500 - would preempt the Authority's service development resources for the year (7.12). It was possible for the AHA(T) to break even financially but its reserves would be eroded and maintenance work delayed (7.13).

Against this background the Authority resolved to investigate the possibility of reducing service levels to a position 'commensurate with available resources in a way sensitive to the needs of the area' (7.14). Stringent cost-saving measures were essential if savings totalling £1 million
over three years were to be achieved (see table 7.1 for a summary of the proposals for achieving this). Though there might be scope for manoeuvre regarding which of these proposals were implemented, it was emphasised that:

'the financial situation itself and any decision ultimately reached by the AHA(T) concerning the levels of saving required, will not be subject to consultation and debate'.

(7.15).

At issue, therefore, was not the extent of the savings required, nor the necessity for them, but rather the way they were to be attained. Serious disruption of services would result unless these savings were achieved; they were also an essential prerequisite for implementation of the priority policies of the AHA(T) (7.16). The financial situation of the Authority worsened throughout late 1979, its severity being slightly understated as a result of significant underspendings at Freeman Road due to non-recruitment of staff (7.17). The AHA(T) therefore considered, at its meeting in December 1979, the implications of this situation for the development of the city's health services. Three major strategic issues were recognised: the commissioning of Freeman Road hospital; the problems of service organisation inherent in providing acute hospital services from three sites, and the priority areas of the service (in particular, geriatric facilities). Four major constraints bound the Authority's scope for manoeuvre: the grave internal financial situation; the limited prospects of increased allocations (whether from the government or the RHA); the pessimistic forecast for public expenditure (see section 7.2 above); and the importance of advancing the Authority's declared strategic objectives (7.18). Against this
Table 7.1 Expenditure control measures approved by Newcastle AHA(T).

<table>
<thead>
<tr>
<th>Year</th>
<th>Measures</th>
<th>Estimated saving (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1979-80</td>
<td>(1) Good 'housekeeping' - small scale economy measures.</td>
<td>100,000</td>
</tr>
<tr>
<td>1980-81</td>
<td>(1) Continuation of the above.</td>
<td>50,000</td>
</tr>
<tr>
<td></td>
<td>(2) Closure of certain hospital units:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Either (a) Walkergate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- close all units and clear site</td>
<td>200,000</td>
</tr>
<tr>
<td></td>
<td>Or (b) Close:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Ethel Watson</td>
<td>50,000</td>
</tr>
<tr>
<td></td>
<td>- West End Chest Clinic</td>
<td>8,000</td>
</tr>
<tr>
<td></td>
<td>- Wellburn Hospital</td>
<td>50,000</td>
</tr>
<tr>
<td></td>
<td>(3) Transfer area headquarters to Sanderson Hospital</td>
<td>50,000</td>
</tr>
<tr>
<td></td>
<td>(4) Direct staffing controls 250-500,000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(to be adjusted depending on progress with (1)-(3) above).</td>
<td></td>
</tr>
<tr>
<td>1980-81</td>
<td>Total</td>
<td>500,000</td>
</tr>
<tr>
<td>1981-82</td>
<td>Walkergate Hospital</td>
<td>50,000</td>
</tr>
<tr>
<td></td>
<td>Area HQ transfer</td>
<td>15,000</td>
</tr>
<tr>
<td></td>
<td>Continuation of (1)-(4) above</td>
<td>N.A.</td>
</tr>
<tr>
<td></td>
<td>Close remaining units from (2) above</td>
<td>108,000</td>
</tr>
<tr>
<td></td>
<td>Further adjustment of direct staffing controls</td>
<td>250,000</td>
</tr>
<tr>
<td></td>
<td>Introduction of further measures requiring changes in clinical management procedures</td>
<td>N.A.</td>
</tr>
<tr>
<td>1979-82</td>
<td>Total</td>
<td>£1,000,000</td>
</tr>
</tbody>
</table>

Source:
Newcastle AHA(T), Area Management Team
Report to the September 1979 meeting of the Authority.
background the Authority's position was:

'exceptionally serious... (they) ought to take whatever action was necessary to keep within the financial limits... the (proposed) reductions appeared to be very savage and would result in drastic cuts in services'.

(7.19)

Moreover, such problems - involving, inter alia, the closure of Walkergate Hospital (see table 7.1) - were emerging at a time when 'almost every acute service in Newcastle could put forward a case for extra beds' (7.20). The financial crisis facing the AHA(T) was therefore so grave that - despite the perceived necessity for service developments - the AHA(T) could not survive without further reductions in hospital services; consequently the proposed reductions in service provision (summarised in table 7.1) were approved (7.21). These reductions assumed still greater urgency early in 1980, when it became clear that the imposition of ad hoc and unplanned cuts in services might be essential:

'(the Authority) could be forced, as part of its statutory duty (7.22), to take short and medium term measures to combat the financial situation. The influence of such measures, because of their arbitrary nature, could well outweigh the effect of any measures contained in the Operational Plan package'.

(7.23)

Moreover, the proposed closure of Walkergate Hospital had become critical to the financial position of the AHA(T). It was argued that if this facility were retained on the grounds that its closure was against the interests of patients and public in Newcastle, this would have certain unintended consequences because:

'if unplanned closures came to pass in order to generate savings, (this) will be somewhat ironic ...(because) effectively this will mean that it has been decided to support maintenance costs and fuel bills at the least efficient hospital in the area'.

(7.24)
Put another way, if Walkergate was not closed, the service reductions that might then follow would have even more serious consequences for health care in Newcastle. The inefficiencies inherent in the retention of Walkergate were such that its closure would generate revenue savings on a scale which would materially assist the AHA(T) to stay within its cash limit. The vital importance of these savings was underlined at the May 1980 meeting of the Authority. In addition to an anticipated underfunding of £431,000 for 1980-1981 (due to the likely effect of inflation), the AHA(T) would also have to recover overspending from the previous financial year totalling £520,000, as well as making the savings of £660,010 proposed in the Area Operational Plan; even without the effect of inflation, then, the required savings totalled £1,180,000 (7.25). In this situation, the more efficient use of resources would not, of itself, be sufficient to solve the Authority's financial problems, and:

'apart from isolated pockets within the area, there was very little scope to make further savings' (7.26)

Reductions in services would therefore be essential. Indeed these financial problems threatened to force the AHA(T) into direct conflict with higher levels of the NHS; it was argued that because of the threat to:

'the whole financial foundation of the Authority... the AHA(T) should revise its patient attitude towards the RHA' (7.27)

As a result of a combination of persistent underfunding relative to the AHA(T)'s perceived needs and because of the alleged failure of the government to provide an adequate allowance for the effects of inflation, the AHA(T) had to
face the possibility of reducing services even though there appeared to be a clear case for their expansion. For example, although the improvement of geriatric care had been identified as a priority (7.28), the closure of Walkergate would delay this until services could be reprovided on the redeveloped Walkergate site. As the consultants in geriatric medicine argued:

'the situation with regard to geriatric provision was already untenable... the prospect of no additional beds within the next five years was totally unacceptable'.

(7.29)

This reinforces the point that irrespective of the proclaimed long-term benefits for the economy of the kind of expenditure restraint discussed here (see section 7.2), certain undesirable consequences were manifest locally as a result of the financial situation of Newcastle AHA(T).

Indeed, if there is a common theme to the proposals for hospital closures in Newcastle in this period, it is the 'inverse care' (Hart, 1971) aspect of the consequences of these proposals. Thus the Walker Park closure was strenuously opposed on the grounds that its accident facilities were invaluable to those employed in the nearby riverside heavy industries (7.30); likewise, the Fleming Children's Hospital was said to be an essential specialist unit, the closure of which (with the concomitant dispersal of facilities and staff) would be against the interests of children's hospital services (7.31); and, as is evident from the above, the intended closure of Walkergate Hospital, for all its importance to the AHA(T)'s financial position, was seen as contradicting one of the Authority's main priorities. In such a situation, the AHA(T)
could do little other than reassure the consultants in
geriatrie medicine that this specialty remained an urgent
priority (7.32). Subsequently, however, this situation was
eased by the RHA's agreement to provide assistance from
regionally-held funds to facilitate the reprovision of the
60 geriatric beds lost from Walkergate Hospital (7.3).

One further problem for the Authority in this period,
related to both the themes touched upon elsewhere in this
chapter - public expenditure restraint (section 7.2) and the
revised hospital policy (section 7.4) - was rationalising the
city's acute hospital facilities. These were split between
three main sites (figure 7.1) and this problem could be re­
garded as an unintended consequence of the decision to develop
a third hospital at Freeman Road (see chapter 10), a decision
which, in addition to these operational problems, also had
implications in terms of the difficulties of commissioning
the new hospital (7.34). Indeed - as noted above - the
Authority regarded the latter as a 'conditioning factor' on
future hospital development (7.35), but serious problems were
experienced in providing the revenue funds to commission this
facility (7.36). The AHA(T) was placed in an extremely
difficult position in this respect. Though it had long been
recognised that the revenue for the new hospital could be
provided only if 'compensating reductions and closures' were
made elsewhere in the area (Newcastle AHA(T), 1977, 10) the
necessity for such closures had become more urgent as a result
of restraints on the resources available to the AHA(T) (see
above). Despite the fact that these problems were in part a
result of government fiscal policy, the Minister of Health in­
sisted that a major capital development at the RVI - the new
440-bed ward block - could proceed only if, as a quid pro quo, the AHA(T) gave assurances that Freeman Road would be commissioned as soon as possible. However, there was no indication from the Minister that additional revenue funds would be available to facilitate the commissioning process (7.37). In this situation, the RHA offered the AHA(T) a 'growth allocation' of an additional £2.5 million to cover the cost of bringing into use the 169 empty beds at Freeman Road (7.38).

Even without the problems of obtaining agreement on the development of the RVI, there were still serious difficulties in developing a strategy for acute hospital provision. The final proposals of the committee investigating this problem are not yet certain, but it is worth concluding this section with an outline of the constraints under which future hospital development in Newcastle will take place, and of the preliminary ideas for this development.

Irrespective of the advantages and disadvantages of the Freeman Road Hospital, there had been some measure of agreement within Newcastle AHA(T) that while - ideally - only two major general hospitals should continue to exist, this was an unattainable objective in anything but the very long-term (7.39). Any attempt to rationalise acute services had, therefore, to be premised on the continued existence of three major facilities of approximately equal size; otherwise, there would be planning blight on any hospital with significantly fewer beds than the others (with consequent implications for staff morale) (7.40). Moreover, plans were restrained by government policy limiting the size of hospitals (see section 7.4) so that any solution involving facilities in excess of circa 800 beds would not be feasible. In addition, since
Figure 7.2: Current proposals for hospital development in Newcastle upon Tyne

Source: Newcastle AHA(T) (Unpublished Papers, 1961)
hospital services from three sites, and the fact that they arose could be taken as a vindication of the arguments of Freeman Road's opponents (see chapter 10 for further details). Irrespective of such an interpretation, the evidence presented here supports the claims of chapter 3 concerning the character of state intervention and this will be examined in the concluding section of this chapter, following a discussion of recent developments in hospital policy.

7.4 'The future pattern of hospital provision in England and Wales': its rhetoric, rationale and implementation.

Though this chapter has stressed continuities in attitudes to public expenditure between Labour and Conservative governments, one issue worthy of close investigation pertains to the Conservative government alone, namely their revision of policy on hospital size (DHSS, 1980a). This section first of all outlines the rationale for reviewing policy on hospital size and summarises the proposals for doing so. The comments of NHS planners are then used to analyse this document in more depth, paying particular attention to the policy's underlying logic, its selective character, and its implications for future hospital development.

In its rhetoric, the document (DHSS, 1980a) appealed to the advantages of small hospitals vis-a-vis DGHs, and to the need for greater flexibility and scope for local initiative in planning. Small hospitals were preferred because they facilitated staff recruitment and had better relationships with the local community; by contrast, DGHs were impersonal, relatively inaccessible and administratively complex. Moreover, the NHS could not afford to lose physical assets; because
of pressure on acute services, patients 'not needing the full panoply of investigation and treatment' could be catered for in peripheral hospitals. Thus the document, at least in its rhetoric, appealed to a 'small is beautiful' ideology (Schumacher, 1973; Illich, 1976) and stressed the virtues of decentralisation and local initiative. Small hospitals were therefore to be retained 'wherever sensible and practicable', and the scale of future hospital provision would be limited. Thus the 'major hospital' in each health district would possess 450-600 beds, with up to 200 additional beds in regional or subregional specialties. To assist in this, psychiatric and geriatric provision in the major hospital would be limited, and indeed it was possible that acute services would be provided on more than one site. Hence more hospitals will be retained and, since this could lead to higher running costs (due to service duplication and staff movements), the DHSS urged that it is essential that:

'the financial premium to be paid for more hospitals on more sites is properly assessed in advance... it follows that the Department does not regard these proposals as a means to secure a reduction in planned capital expenditure'.

(7.43)

Thus the emphasis in policy has shifted from a concentration of services in a small number of single-site DGHs, to a more spatially decentralised pattern of provision.

However, RHAs and AHAAs felt that an inadequate case had been made for a review of policy. The Northern RHA claimed that the case was 'thinly argued and unconvincing' (7.44), justifying its proposals by reference to 'non-specific observations and sweeping generalisations' (7.45). Support for small hospitals was 'emotional rather than rational' (7.48), being based on 'the instant judgement that small is
beautiful' (7.47). Moreover, several arguments favouring, for instance, a more decentralised pattern of services, had become part of the conventional wisdom; yet, on closer examination, 'they have no real substance' (7.48). The case presented thus relied on generalisation and assertion, rather than evidence and sound argument.

There were also clear inconsistencies in the document's arguments. The maximum hospital size would be 600 beds if only district specialties were provided, but, if subregional and regional specialties were to be available, 200 additional beds would be permitted. This could be taken to mean that:

'the communications, management and other problems which should be used as a basis to restrict hospital size will not occur in a hospital of over 600 beds provided that any additional beds are in regional or subregional specialties'.
(7.49)

The distinction between the two maxima is thus spurious and the Northern RHA felt that if the policy was really about hospital size, the DHSS would have done better to specify a 600-800 bed size range, 'irrespective of the specialties of the beds' (7.50).

In addition, although the Minister of Health was wary of setting up a rigid or inflexible policy (7.51), it was still felt that insufficient consideration had been given to the 'immense variations in local circumstances' to which the policy would have to be applied (7.52). Indeed, flexible planning may not actually have been a priority. Before the document's publication, RHAs had been required to review major hospital planning schemes, 'on the assumption that the new initiatives will be accepted as a prescriptive policy, and are right' (7.53). However, the document's weakness had created a 'climate of suspicion' (7.54) for two reasons. Firstly, in
an area requiring over 600 beds, the implied dispersal of services would increase both staff and patient travel and the complexities of service organisation (7.55). Secondly, if hospital units fell below the minimum size specified by the Royal Colleges of Medicine for staff training purposes, it would not be possible to provide all the facilities of a DGH on one site hence a poor 'mix' of facilities could result (7.56). Consequently the new policy could be detrimental to patient care.

Moreover, the document was selective in the options included and excluded; it referred neither to providing hospitals in communities which do not currently possess them, nor to the possibility of redeveloping existing facilities. The latter could be seen as a 'manifest requirement' of future policy given the condition of much of the hospital stock, whereas the former was an 'inescapable consequence' of the document's logic (7.57). Since both options would involve heavy capital investment, it could be argued that, despite assertions to the contrary, the underlying intention was to justify the restraint of capital expenditure.

Finally, the confusion created by the document is exemplified by the following:

'the policy document is as remarkable for what it omits as what it actually says... (it may have) little rational basis, deriving primarily from considerations of political acceptability and popularity'.

(7.58)

Indeed, the document's outcomes were likely to diverge from its aims. Thus multi-site DGHs were favoured in urban areas, yet these would be subject to all the disadvantages put forward as reasons for moving away from large-scale DGH
development (7.59). In rural areas, where accessibility is of prime importance, there is no guarantee that the new policy would improve this. Indeed, it could have precisely the opposite effect, since only a limited range of services could be provided in each of a dispersed set of facilities.

As for the effect of this document on the policy of the Northern RHA, only six acute hospitals exceed the 600-bed maximum size; these are the three main hospitals in Newcastle, and the Sunderland General, North Tees General and Darlington Memorial Hospitals, and all possess regional or subregional specialties. The new policy was to prove an important constraining factor on the development of hospital strategy in Newcastle (see section 7.3), Sunderland (see Chapter 10) and Cleveland, where the South Cleveland DGH development was scaled down from 1200 to 832 beds (7.60). However, proposals for Gateshead and North Tyneside AHAs were approved only when the retention of a small hospital had been agreed in order to keep the size of the main facility to around 600 beds. Thus the original aim had been to develop the DGH in North Tyneside to 686 beds, but approval was given to this only after the retention of Moor Park Hospital was agreed, so as to keep the size of the DGH to 630 beds (7.61). Similarly, plans for development in Gateshead were endorsed on condition that Whinney House Hospital was retained as a community hospital, for similar reasons (7.62). This 'somewhat shallow' basis for a policy review supported the claims of local administrators that, despite its rhetoric about flexibility and decentralisation, the policy revision was essentially a thinly argued case for restraining capital expenditure (7.63). The prescriptive application of the policy supported such a view
Finally, a comparison of this document with the 1962 Hospital Plan illuminates the changing character of state intervention in health care provision. The Hospital Plan emphasised the scope for rationalising NHS current expenditure via the provision of a system of modern, efficient and large-scale (600-800 beds and above) DGHs. This was based on several studies not only of NHS bed norms but also of the economics of hospital planning. By contrast, the substance of the comments of NHS planners on the 1980 document (summarised here) was that this policy guidance relied on relatively weak arguments and unsupported assertions. Taken in conjunction with the application of the policy, it seems that the underlying rationale is the restriction of new capital expenditure, consistent with the broader macro-economic intentions of the current government. While the 1962 Plan advocated a minimum DGH size of 600-800 beds, this had become a maximum size range by 1980, with rather different implications in terms of the amount, quality and spatial pattern of hospital provision. Figure 7.3 shows that the likely outcome of current policies will be a rather more decentralised spatial pattern of services than that originally envisaged (figure 7.4). Thus while both the documents referred to were, in a sense, concerned with public expenditure restraint, they attempted to achieve this in different ways. Whereas the Hospital Plan sought to improve the efficiency of the hospital service by rationalisation and new construction, the 1980 document attempts to deny claims for new capital developments and encourages retention of the existing capital stock, as far as is possible. These different policies are indicative of
Figure 7.3: Possible outcome of the Northern RHA's current hospital strategy

Figure 7.4: Original intentions of the Hospital Plan for the area served by the Northern RHA
broader changes in attitudes to public expenditure during the 1962-1980 period. At the time the Hospital Plan was announced, public expenditure was viewed as one of the most important mechanisms available for economic management; by contrast, current attitudes are such as to question the utility of public expenditure, leading to attempts to restrain it via the kind of policy discussed here.

7.5 Concluding comments

The foregoing discussion presented, firstly, a summary of important developments related to public expenditure and NHS planning, in order to provide an appropriate context against which to interpret the empirical evidence of sections 7.3 and 7.4. The former of these demonstrated the problems posed for local planners by public expenditure reductions and/or restraint; the latter analysed the most recent changes in policy on hospital size. The following points should be emphasised.

Firstly, this period was essentially one of retrenchment and crisis in NHS planning. This was manifest from the level of central government, graphically exemplified by the quote from Barbara Castle (1980, 359-360 - see section 7.2), down to the local scale (exemplified by events in Newcastle AHA(T)). Indeed, as the fiscal crisis of the state deepened in the late 1970s, as a result of a combination of rapid inflation and government fiscal policy, the limits to state intervention were increasingly evident. References in the minutes of the Newcastle AHA(T) to the lack of scope for manoeuvre of the Authority, to the impossibility of solving its problems simply by more efficient management, and to
the need for reductions in service provision despite the manifest requirements of the AHA(T), all support such an interpretation. In Offe's (1975, 246) terminology, the necessary had indeed become impossible and the impossible necessary.

It is evident, furthermore, that notwithstanding the declared intentions of certain state policies, their objective impacts diverge from these aims. Cash limit policies exemplify this; initially introduced as a means of ensuring tighter control over public expenditure, they have increasingly been employed to set definite targets outside which expenditure must not stray. This in turn - particularly in the last three years (due to increased VAT and inflation) - has led to volume cuts in services, contradicting the declared intentions of the Conservative government that NHS spending should be maintained in real terms. Moreover, when service reductions have resulted, responsibility for their implementation has been devolved to the local levels of NHS administration. Consistent though this is with the government's declared intention of increased decentralisation in administration, it is disturbing that this occurs given that such reductions (as Newcastle AHA stressed - see quote 7.11 above) were the direct consequence of government fiscal policy. It is interesting to contrast this with the employment of the revised hospital policy in a prescriptive manner, to constrain capital development at the local level, despite the proclaimed intention of this policy to increase scope for local autonomy in planning.

A further important point to emphasise here is the changing character of state intervention in the economy. This
is best exemplified by reference to the contrast between the Hospital Plan and most recent developments in policy. The increasingly technical character of NHS resource allocation and planning (see DHSS, 1976a, b, c) also falls into this category and this can best be seen as an attempt by the state to reduce political issues to technical problems, in the face both of expenditure restraint and increased demands on the service. Though their implications for provision of and access to health care have not been considered directly, the expansion of the independent hospitals, and the anti-collectivist philosophy of the 'new right' (Taylor-Gooby, 1981) also exemplify the changing character of state intervention and its consequences for public sector provision. Clearly the implications of such policies require more detailed analysis.

The final issue to be noted here concerns the selective character of state policy formulation. This is evident, at the most general level, in the rolling back of the boundaries of the state intervention since 1979. More specifically, the role of ideology has evidently been crucial in terms of its influence on attitudes to public expenditure and to public service provision which have increasingly been seen as a burden on capital accumulation and as an inefficient way of providing services. Consistent with such attitudes are policies which exclude certain options from consideration - for instance, the revised hospital policy (7.4).

Thus the evidence presented has illustrated the consequences of public expenditure restraint for health service and hospital planning in the 1974-1982 period, and has provided further evidence in support of the views advanced
above concerning the capitalist state. The characterisation of the state's interventions as being selective in nature, increasingly crisis-prone and changing in character over time, seems particularly apposite in this light.
Footnotes

7.1 Barbara Castle was Minister of State at the DHSS, 1974-1976; her Diaries (Castle, 1980) provide graphic accounts both of the pressures on the Labour government to reduce state expenditure, and of the problems of public expenditure planning in this period.

7.2 See, inter alia, Newcastle Journal, 9.8.74, 20.8.74, 18.2.75, 19.2.75, 17.3.75, 12.6.75, 21.1.76, 7.2.76; Newcastle Evening Chronicle, 28.11.74.

7.3 These problems were posed most acutely in London. For instance, in late 1978, the Lambeth, Southwark and Lewisham AHA refused to implement certain reductions in services. This provoked direct ministerial intervention (see letter from David Ennals to Lambeth, Southwark and Lewisham AHA, 8.12.78 - copy held in RHA 86/51).

7.4 Note by the Regional Administrator, Northern RHA, on Subregional Capital Allocations, 1.3.76 - held in RHA 529.

7.5 See, for instance, Avery-Jones (1976), and also various items of correspondence in the British Medical Journal.

7.6 Newcastle AHA(T), meeting held on 10.9.76, minute 76.128.

7.7 Newcastle AHA(T), July 1976 meeting, minutes 76.108, 76.109.

7.8 Newcastle AHA(T), November 1976 meeting, minute 76.168.

7.9 Newcastle AHA(T), January 1978 meeting, minute 78.4.

7.10. See the Northern RHA's Financial Reviews. For example, the AHA(T)'s revenue account was slightly underspent in 1976-1977 (1.05%), 1977-1978 (1.81%) and marginally underspent in 1978-1979. The under­spendings were largely due to delays in commissioning Freeman Road Hospital.

7.11 Noted in a report by the Area Management Team to the AHA(T)'s meeting on 27.7.79. This document also claimed that the fiscal policies referred to: 'effectively reduce the volume of service which can be delivered in this financial year and which, by implication, had been agreed in the determination of the official revenue allocation for the year'.

Again, this serves to reinforce the point that irrespective of the rhetoric of the Conservative government's policies (for example, their claim that NHS services had been maintained in volume terms) the actual outcome of these policies was a reduction in service provision.
7.12 Ibid.
7.13 Newcastle AHA(T), meeting 27.7.79, minute 79.102.
7.14 Ibid.
7.15 Letter from the Area Policy and Planning Administrator, 20.9.79, enclosed with the report of the Area Management Team to the AHA(T)'s meeting on 28.9.79 - emphases added.
7.16 Newcastle AHA(T), meeting 28.9.79, minute 79.130.
7.17 Newcastle AHA(T), meeting 26.10.79, minute 79.152.
7.18 These points were raised by the Chairman of the AHA(T) at the Authority's meeting on 21.12.79, minute 79.191.
7.20 Ibid.
7.21 Ibid.
7.22 The statutory duty referred to is the obligation on the AHA(T) to contain expenditure within its cash limit.
7.23 Newcastle AHA(T), unpublished report on 'Consequential adjustments to acute hospital services arising from the proposed closure of Walkergate Hospital', 19.3.80 - emphasis added.
7.24 Ibid., emphases added.
7.25 Newcastle AHA(T), meeting 23.5.80, minute 80.81.
7.26 Ibid.
7.27 Newcastle AHA(T), meeting 27.6.80, minute 80.98.
7.28 Geriatric services had been declared a national priority in 1976 (DHSS, 1976b). Various debates in Newcastle AHA(T) meetings identified this as an urgent local priority, viz. the meetings of 10.9.76 (minute 76.128), 21.10.78 (minute 78.145), 26.1.79 (minute 79.4) and 21.12.79 (minute 79.191).
7.29 Newcastle AHA(T), Area Medical Committee, meeting 11.3.81, minute 81.18 - emphases added.
7.30 This point was emphasised in the Newcastle Evening Chronicle, 5.7.77; and also in Newcastle CHC's papers produced in the course of consultation on the closure with the AHA(T), particularly reports 1 (General Comments), 4 (The Public's Views) and 5 (note of a
7.30 (cont) meeting with Newcastle City Council's Priority Area Team for Walker) (papers held in Newcastle CHS offices).

7.31 Newcastle Journal, 9.1.76, 24.2.76, 27.2.76, 25.3.76, 3.4.76, 13.4.76, 24.7.76. In particular, on 27.2.76, medical staff of the Fleming Hospital were reported as objecting to the dispersal of vital specialist services.

7.32 Newcastle AHA(T), Area Medical Committee, 11.3.81, minute 81.18.

7.33 Newcastle AHA(T), unpublished summary of comments on the proposed closure of Walkergate Hospital.

7.34 This is not to suggest, however, that these operational and commissioning problems would not have occurred had the city's third hospital been located in central Newcastle (as several prominent politicians, planners and consultants had wished - see chapter 10).

7.35 See note 7.8

7.36 Newcastle Journal, 15.9.76, 16.9.76, 5.10.76, 27.10.76, 3.11.76, 24.3.77; Newcastle AHA(T), December 1977 meeting, minute 77.145; meeting 24.11.78 minute 78.169; January 1979 meeting, minute 79.4. One unintended consequence of the delays in commissioning the hospital was that the underspending at Freeman Road assisted the AHA(T) in keeping within its cash limit.

7.37 Newcastle Journal, 30.7.80, 2.10.80, 4.11.80, 29.11.80, 18.12.80, 28.2.81; Newcastle Evening Chronicle, 15.10.80, 31.10.80.

7.38 Newcastle Journal, 27.9.80.

7.39 Newcastle AHA(T), January 1978 meeting, minute 78.4.


7.41 Ibid., p.15.

7.42 See the discussions in the following meetings of the AHA(T): 26.1.79, minute 79.4; 27.4.79, minute 79.51; 21.12.79, minute 79.191.

7.43 The foregoing has been substantially abstracted from the Consultation Paper (DHSS, 1980a). Copies of the unpublished documents referred to hereafter are held in the Northern RHA Planning Division offices.
7.45 Northern RHA - internal memorandum, 21.8.80.
7.47 Northern RHA - internal memorandum 21.8.80.
7.48 Ibid.
7.50 Ibid.
7.51 Introduction to DHSS (1980a) by G. Vaughan, MP.
7.52 Northern RHA - comments on the Consultation Paper, August 1980.
7.54 Ibid.
7.56 Ibid.
7.58 Northern RHA - internal memorandum, 21.8.80.
7.59 Nuffield Centre for Health Service Studies (1980). The future pattern of hospital provision; a need for parallel policies (mimeo).
7.60 Northern RHA, appendix to comments on the Consultation Paper, August 1980.
7.61 Ibid.
7.62 Ibid.
7.64 Association of Chief Administrators of Health Authorities - comments on the Consultation Paper, August 1980.

8.1 Introduction

This chapter is divided into three sections. Firstly, an account is presented of important issues in intra-regional spatial policy. This facilitates an understanding of why the issues discussed at greater length here (and in Chapters 9 and 10) are of particular interest. The reasons for the designation of Washington and Peterlee new towns, and for the proposals for urban redevelopment in Newcastle, are therefore discussed in section 8.2. The problems posed for hospital planning by new town development are examined (section 8.3), and the links between the urban redevelopment of Newcastle and hospital planning are analysed in section 8.4.

8.2 Intra-regional spatial policy in North East England: a brief sketch.

More comprehensive accounts of this topic are available (Carney and Hudson, 1974; 1976; 1978; Hudson, 1976) and here only two issues are discussed. These are proposals for settlement concentration policies and new town development and, secondly, the view of the Hailsham Report (Board of Trade, 1963) that a spatial concentration of public sector investment was a prerequisite for industrial regeneration in the North East.

Proposals for settlement concentration within the North East can be traced to a consensus view, established among the region's bourgeoisie in the 1930s (Carney and Hudson, 1978), that the future of industry in the region depended on
guaranteeing a sufficient supply of male labour in certain locations. Likewise, the influential Pepler-MacFarlane Report (Pepler and MacFarlane, 1949) argued that future settlement patterns would have to be geared to the attraction of male-employing industry to replace jobs lost in the region's declining basic industries. Thus:

'the framing of industrial policy is outside our provenance. All we can do is endeavour to fit that policy to the facts of the land in a manner which will serve the needs of industry and... secure for the people an environment appropriate for good living'.

(Pepler and MacFarlane, 1949, 22 - emphasis added)

Future industrial development would also require a 'wholesale expansion of public services' and a modernisation of the existing infrastructure (Pepler and MacFarlane, 1949, 22). Populations of a certain minimum size were necessary to guarantee the provision of this infrastructure. This implied concentrating public investment and industrial development at selected locations. It was assumed that the requisite labour force would move to the areas specified, given suitable employment opportunity and a modern environment (Pepler and MacFarlane, 1949, 63, 267-268). Such views were translated - in County Durham - into specific proposals in the County Development Plan (Durham CC, 1951). This advocated a fourfold categorisation of settlements, based on an assessment of their potential for future industrial growth. Public sector investment would be concentrated in certain locations deemed to possess potential for future growth, while other settlements were denied such investment on the grounds that their 'viability' would be threatened by future socio-economic and demographic changes (Durham CC, 1951).

The implementation of settlement concentration policies
is not discussed further here (see Blackman, 1981; Carney and Hudson, 1976; Snowdon, 1979). However, one way the more general objectives of settlement concentration could be achieved was via new town development. The designation as a new town of Peterlee (and, later, of Washington) has to be set against the background of the more general acceptance of new towns as a policy instrument.

Proposals for new town development date back at least to the 19th century. They stemmed partly from enlightened self interest on the part of industrialists, and partly from idealistic visions of an alternative society (Shaffer, 1970; Robinson, 1978). However, the potential value of new towns in spatial policy was not recognised until the Barlow Report (Royal Commission on the Distribution of the Industrial Population, 1940). Subsequently the Greater London Plan (Abercrombie, 1944) advocated such developments as part of a policy of metropolitan decentralisation, and the Reith Committee (New Towns Committee, 1946) put forward influential proposals. Thus new towns were to be run by Development Corporations (NTDCs) which, though charged with a range of functions, were given no statutory power for health service provision. Nor was appropriate administrative machinery set up to guarantee cooperation between NTDCs and other statutory organisations. Joint planning between NTDCs and other organisations has therefore been ad hoc in character. Although new towns and the NHS were set up and developed together, the mutual benefits have been minimal. The relationship between the NHS and other statutory agencies will receive more detailed examination below.

New towns could be developed in two sets of
circumstances: to facilitate decentralisation (e.g. the London new towns) and to concentrate population in areas of dispersed settlement. Peterlee was ultimately to be chosen to fulfil the latter function. The recommended size of new towns (30-50,000) represented a compromise between being large enough to support social facilities and provide a sufficiently large labour force for industrial development, and being small enough to provide a sense of community. As regards economic and social objectives the attraction of stable male employment was a key goal, and was essential if new towns were not to become dormitory towns. Social goals, by contrast, were often vague and idealistic; moreover, given that no legislative action was taken to ensure the cooperation of other relevant planning agencies, it is perhaps not surprising that there is a considerable gap between the stated intentions and actual results of new town development (Robinson, 1978, 29). The above represents only a sketch of the origins of new towns (see, inter alia, Shaffer, 1970; Robinson, 1978; Wirz, 1975). The specific factors underlying the development of Peterlee are now examined, drawing on the commentaries of Steele (1962), Leishman (1971) and Robinson (1978).

Initial proposals for new town development in the Easington area emerged within the Easington RDC between the wars, not only as a means of avoiding 'sprawl' and 'ribbon development', but also because several local villages lacked, or were likely to be deprived of, an economic base due to mine closures. Initially, growth in more than one centre was favoured, but it subsequently became clear that development was to take place on only one site. This was due, in large measure, to the influence of C.W. Clarke, the clerk to Easington
RDC. He had actively pursued the case for new town development as a means of reforming social and economic conditions in the Easington area. Improved living conditions for miners were seen as essential if an adequate labour force was to be retained for coal mining; the quality of the built environment had been perceived as a hindrance to recruitment (Clarke, 1947). Backed by the RDC, Clarke pursued this matter with the Ministry of Town and Country Planning. The latter proved receptive, both because of the extent of local support and the perceived necessity to guarantee coal supplies. The new town of Peterlee was designated in March 1948; its target population was 30,000, and it was seen as a future urban focus for the Easington area, offering services which, it was felt, could not be provided economically in the surrounding pit villages. The extent to which this intention was realised, in the context of hospital planning, will be examined below.

The next major issue for consideration here is the emergence of the Hailsham Report in 1963, though this is not to imply that no developments took place in intra-regional spatial policy in the 1950s. New towns received slightly less direct support from the Conservative government (elected in 1951), who preferred financial backing for such developments to be provided jointly by local authorities and central government, under the terms of the 1952 Town Development Act (Hudson, 1976, 101; Leishman, 1971, 66). Settlement concentration policies were still pursued, but there was no real attempt to steer industrial development towards specific locations within the region; the whole of the North-East coalfield was accorded Development Area status (McCrone, 1969).

However, a rather different policy was pursued in the early 1960s. The potential for long-term planning of the economy,
involving explicit use of public sector investment as an instrument of economic management had been recognised in the late 1950s (Jessop, 1980). One aspect of this was the emergence of specific public sector investment proposals for North-East England. The appointment of Lord Hailsham as Minister with special responsibility for the North-East reflected government concern at the unemployment rate in the region (4% in January 1963). The report which followed Hailsham's appointment advocated a rapid rise in public sector investment, in order to modernise the region's social and economic infrastructure, and thus facilitate industrial development. In particular, the urban environment was to receive special attention; within the overall 'growth zone' bounded by the coast, the A1 and the three industrial estuaries of the region) investment was to be concentrated on specific locations, (Board of Trade, 1963, 6-7). Thus Newcastle was seen as a regional capital which was to play a central role in assisting in - even leading - the modernisation of the North East. The following is illustrative of this view:

'In a region in the midst of changing its economic base, the capital city must be at the head of renewal and in the forefront of providing what modern man expects in a modern environment'.
(Burns, 1967, 2).

The absorption and promulgation of this kind of view by parties to the dispute over hospital strategy for Newcastle, had significant effects on the type of policies advanced and upon the progress of negotiations in this dispute (see below; see also chapters 9,10).

A second growth point (within the growth zone referred to) was to be Washington new town. This had been proposed as a potential new town site in the Pepler-Macfarlane Report, but
definite support for such a development was not forthcoming until the late 1950s, when Durham CC proposed that industrial development should take place in the vicinity of Washington, to cater for the growing population of north-east Durham. Leishman (1971, 65) argues that this reflected not so much the Council's desire to improve the built environment of that area, but rather its concern that it would lose its large towns on the industrial estuaries in a future local government reorganisation. Industrial development at Washington would therefore partially compensate for the resultant loss of rates income. These initial proposals for new town development were not received favourably, on the grounds that Washington, being located in between Tyneside and Wearside, could not form a self-contained community (Leishman, 1971, 67). However, the Hailsham Report rejected such a view on the grounds that a new town at Washington would 'help to stimulate faster progress in raising the scale and quality of the region's urban development generally' (Board of Trade, 1963, 27). Washington thus exemplifies a policy of uneven intra-regional development which was justified in terms of the reduction of inter-regional differentials (Hudson, 1982, 667). Following the approval of the Hailsham Report, Washington was designated as a new town early in 1964.

The foregoing brief sketch of issues in spatial policy within postwar north-east England has outlined points which relate directly to postwar hospital planning and to Chapters 8-10 of this thesis in particular. Hence the implementation of (for example) the settlement concentration policy in County Durham, or the proposals in the Hailsham Report, have not been examined in detail; rather this introduction is a background
which is necessary for a full understanding of the issues of local hospital policy to be discussed in the next section.

8.3 Hospital planning and new town development: the cases of Peterlee and Washington

In discussing the interrelationship between hospital planning and the development of new towns the policy intentions of NHS and other state agencies will be examined closely. Areas of divergence and convergence of intentions will be highlighted. This account is somewhat exploratory in character, due largely to the relative paucity of the evidence available.

At the time of the Hospital Surveys, considerable indecision existed as to the future form and organisation of the postwar hospital services (see chapter 4). Consequently the surveyors could not commit themselves on what developments were most appropriate. However, their views on the problems of planning in North-East England show consistency with the proposals advanced at that time for settlement planning.

Thus:

'the future prospects of industry in the North-East are still uncertain, and the possibility that there may be important changes in the size of the population must be taken into account in any reorganisation of the hospital service... plans for... (such a reorganisation) must not be too rigid'.

Ministry of Health, 1946 (volume 10), 4).

Note, in particular, the argument that changes in population distribution within the region were necessarily dependent upon the 'prospects of industry' - a view which closely parallels the rationale for the settlement concentration proposals discussed above. Of the population changes at which this document hinted, the most important developments have been associated with the growth of new towns, in particular
at Peterlee and Washington. The reasons for the choice of these locations have been sketched in the previous section. Here the response to the development of these towns is examined. Figure 8.1 shows the location of Peterlee and Washington in relation to existing hospital facilities; though the two new towns were designated at different dates, only minor changes took place in the availability of hospital facilities and these are indicated on the map.

The Hospital Surveyors proposed serving the Peterlee Easington area from hospitals at Sunderland and Hartlepool (Ministry of Health, 1946, 59, 90). This preceded the designation of Peterlee, but it soon became evident that the RHB were interested in providing a hospital there. For example, four possible sites had been identified in a preliminary meeting on hospital development, though subsidence would delay the availability of two of these for at least 15 years (8.1). Peterlee was actually regarded as the RHB's third highest priority for development, following the West Cumberland and Bedlington areas (8.2). The RHB argued that the population of the Peterlee and Easington area were not receiving an adequate service if they had to travel to Sunderland where, in any case, the hospitals were already under pressure (8.3). The RHB therefore agreed to provide a 300-bed general hospital, capable of expansion to 500 beds (8.4).

However, the conflicting intentions of the RHB, the NCB and the NTDC were to hinder this proposal's implementation. At the time of Peterlee's designation, a substantial amount of coal remained to be extracted from seams beneath the site and, if subsidence was to be avoided in the new town, it was essential that this be recovered quickly. In conveying land to the NTDC, the NCB had insisted that their approval be sought
Figure 8.1: Location of Peterlee and Washington in relation to existing facilities
for future surface developments. Clearly, construction of a large building such as a hospital would demand particular caution with regard to choice of site. The details of the negotiations between the NCB and the NTDC are not directly relevant here (on these, see Robinson, 1978; Steele, 1962, 107-152) but by late 1953 the NCB was in arrears with its programme for coal extraction. This would delay the availability of the site previously offered to the RHB, but the same land could be used almost immediately for light structures, such as housing. It was likely that the RHB would not be able to provide a hospital for some time due to constraints on the resources available for capital development (see Chapter 5). The NTDC were therefore anxious not to leave an 'undeveloped hold' in Peterlee (8.5). They were also keen to minimise disturbances to and restrictions on the extraction of coal; unless they achieved this, they 'could hardly expect much help from the NCB' (8.6). Thus while the NTDCs wished to develop social provision in Peterlee, this was subordinate to the requirements of the NCB to maximise coal production; the RHB were therefore offered an alternative site which they accepted (8.4).

Thus, although Peterlee had been a high priority for hospital development in the early postwar years, this development had not occurred due largely to constraints on capital investment in the NHS. Uncertainty also existed as to the site to be occupied by the proposed hospital. However, Peterlee evidently slipped down the list of the RHB's priorities in the late 1950s. The reasons for this are not clear; the slow growth of Peterlee may have been a contributory factor, and there were also pressures to give a higher priority to other areas served by the RHB - such as Teesside (8.8). Changing attitudes to the
size of general hospitals (see Chapter 5) may also have swayed the RHB against Peterlee and, as the RHB pointed out, there already existed four hospitals close to Peterlee (8.9) (see figure 8.1). In the NTDC’s opinion, however, the continued existence of such facilities contradicted the aim of developing Peterlee as a service centre for the Easington area and, indeed, was at variance with settlement concentration policies more generally (8.10). Though the RHB attempted to placate the NTDC by indicating their willingness to provide consultative outpatient facilities in a health centre (8.11), the NTDC objected to this on the grounds that they had reserved a site for a hospital for several years and this had influenced Peterlee’s development (8.12). Subsequently, indeed, the NTDC informed the RHB that the site they had reserved might no longer be available should it be required at a later date (8.13). The RHB’s view, however, was that while population growth had taken place in the Easington/Peterlee area, it had been distributed evenly between HMCs (table 8.1), and so there was no case for additional development in any one HMC. Furthermore, the rundown of the coal industry from 1958 (see Krieger, 1979) and the 'uncertain' prospects for the attraction of other sources of local employment, combined to make it uncertain whether the anticipated population growth in the Easington area would materialise (8.14). Although the population of the Shotton/Peterlee area were the most distant from a general hospital (in the area under consideration, 80% (109500) were between 5 and 7½ miles from a hospital, whereas approximately 20% (24,620) were 8-10½ miles from their nearest general hospital), the RHB claimed that the apparent inequality in access was compensated for by the position of Shotton/Peterlee in between HMCs. Hence greater choice was available. Thus the
Table 8.1 Summarised population estimates for HMC catchment areas in East Durham, 1954-1959.

<table>
<thead>
<tr>
<th>HMC Area</th>
<th>Registrar-General's Estimated 1954 Population</th>
<th>Registrar-General's Estimated 1959 Population</th>
<th>Change +/-</th>
<th>Per cent (%) Change +/-</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sunderland</td>
<td>359,400</td>
<td>371,380</td>
<td>+11,980</td>
<td>+3.3</td>
</tr>
<tr>
<td>Durham</td>
<td>133,740</td>
<td>136,480</td>
<td>+2,740</td>
<td>+2.0</td>
</tr>
<tr>
<td>Hartlepool</td>
<td>133,620</td>
<td>138,625</td>
<td>+5,005</td>
<td>+3.7</td>
</tr>
<tr>
<td>North Teesside</td>
<td>141,770</td>
<td>149,530</td>
<td>+7,760</td>
<td>+5.4</td>
</tr>
<tr>
<td></td>
<td>768,530</td>
<td>796,015</td>
<td>+27,485</td>
<td>+3.6</td>
</tr>
</tbody>
</table>

Source:
RHB considered that the evidence did not justify developing a new hospital in the Peterlee area (8.15). Following the Hospital Plan (Ministry of Health, 1962) it was evident that Peterlee could not be considered as a potential DGH, purely on the basis of the relatively small catchment population of such a facility. However, the RHB were still attempting to provide consultative outpatient services at a health centre in Peterlee; pressures for this had not only resulted from the RHB's desire to see some sort of hospital provision in Peterlee, but also from local pressures (8.16), not least among which were those from GPs concerned at the necessity to employ overseas doctors in the Peterlee area, due to the difficulty of attracting British GPs (8.17). Subsequently, the RHB continued to consider schemes for outpatient provision (8.18) and the Peterlee health centre ultimately provided such services. However, the question of hospital provision did not reappear on the political agenda until the late 1970s (see Chapters 9, 10). Since the Peterlee case shares certain common features with developments at Washington, these developments are now discussed.

Prior to Washington's designation, the Sunderland HMC did not regard Washington UDC as an area to be served by their hospitals; only 33 patients from that area had been treated in Sunderland HMC's hospitals during 1960 (8.19). As formally stated in the Hospital Plan, and confirmed by local NHS planning agencies (8.20), major DGH developments were to take place at Sunderland DGH and Ryhope (see figure 6.2). However, following Washington's designation, a RHB document noted the possibility that a third DGH could be required, depending on Washington's growth (8.21). The Ministry of Health endorsed this in suggesting that Sunderland HMC's planning population be modified (8.22).
The RHB's initial reluctance to consider providing a hospital in Washington seems to have stemmed from their concern that there was no 'natural drainage' of population to Washington. A hospital in that town would therefore have only a limited catchment population and it would not relieve the pressure on the two other DGHs in Sunderland HMC (8.23).

However, the RHB subsequently revised their opinion, partly because of the anticipated population growth in Washington (8.24), and partly because of the lack of alternative sites within the HMC. The RHB still had reservations due to the relatively low population which such a hospital would serve (8.25) but perhaps a crucial factor in encouraging them to develop a hospital at Washington was the possibility that Washington's population might seek hospital facilities in Gateshead (the DGH there - (the Queen Elizabeth Hospital) - being only three miles from Washington - figure 8.1) if a hospital was not available in the new town. This would be a 'serious embarrassment' to the RHB, as it would greatly overload the capacity of Gateshead HMC's hospitals (8.26). Hence the RHB's provisional agreement to the development of a hospital in Washington (8.27).

However, and as at Peterlee, the precise timing of such a development remained open to question; it could not be accommodated within the RHB's ten-year capital programme (8.28). For the NTDC this posed the problem of 'sterilising' 30 to 40 acres of land; it was likely that there would be considerable pressure on the NTDC to release this, particularly if the proposed rapid growth of Washington actually took place. As a compromise the RHB expressed an interest in experimenting with alternative arrangements for health service provision (see below). Two other issues also concerned the RHB, namely, the proposed
ultimate size of the town and the location of the site to be occupied by the hospital.

The RHB were particularly concerned that Washington might never reach its projected size. Its target population - 80,000 - was seen as an upper limit to growth, and the RHB were especially concerned about the following observation in the Master Plan for Washington:

'it must be largely a matter of speculation how much of the migration to Washington... will be made up of overspill'  

(Llewelyn-Davies, Weeks, and Co., 1966, 40 emphasis added)

For instance, some of the intended overspill from Wearside was unlikely to materialise because of a decision to build Silksworth township to cater for overspill from Sunderland (Llewelyn-Davies, Weeks and Co. 1966, 40). The RHB therefore feared that the viability of a hospital in Washington would be threatened, as the Master Plan envisaged that it was unlikely that much overspill would take place in the early years of Washington's development (Llewelyn-Davies, Weeks and Co., 1966, 40) and so voluntary migration to the town was of paramount importance. Such migration was, by definition, beyond the control of the NTDC, and so the RHB felt justified in delaying any proposals for hospital development at Washington (8.29).

The RHB also had reservations on the location of the hospital, preferring a central location to the peripheral site allocated by the Master Plan (8.30), because a central site would facilitate integrating the services provided by the NHS, and would also integrate the hospital more fully into the community. In addition, it would facilitate attraction of the labour force necessary to run the hospital. The RHB argued
that one implication of a national labour shortage was an increasing dependence upon part-time staff and this would imply the employment of married women. Since the time-space budgets of married women are constrained by their domestic responsibilities, a central site for the hospital would permit such women to carry out those duties requiring the facilities of the new town (e.g. shopping) at the beginning or the end of their daily professional commitments (8.31).

However, since - as has been mentioned above - the construction of a hospital for Washington was unlikely to take place for some years, the precise services to be provided in a health centre had to be agreed upon. Though the RHB indicated their willingness to provide consultative outpatient services from a health centre (8.32), the NTDC continued to press the RHB for additional facilities, arguing in particular that maternity and accident facilities were necessary, given the actual and projected nature and composition of the town's population (8.33). The RHB therefore considered seriously the possibility of providing specialist services at a health centre in Washington (8.34). Though this appeared to contradict their earlier decision on services for Peterlee - where the RHB had decided to provide outpatient services only (8.35) - the evidence suggests that the RHB were willing to consider more flexible approaches to health service provision in new towns. Washington therefore offered an opportunity for experiment (8.36), particularly in the light of the experience of other new towns (on which, see inter alia, Sichel, 1969a, b; 1970; Draper et al, 1971; Dillane, 1966; Reid and Gooding, 1975; Parston, 1980). There developed local opposition to proposals for such development, however; though senior officials of the RHB were undoubtedly anxious to provide some consultative
or specialist facilities through a health centre (8.37), local medical opinion was against such a proposal. This was because of shortages of medical staff (so that concentration of services and personnel was desirable); the nearness (under five miles) to Washington of hospitals in the Gateshead, Durham and South Shields HMCs; the fact that the RHB had not endorsed similar proposals for Peterlee; and the complications that could develop with staffing arrangements if the proposed hospital were to be built locally (8.38). However, it would be too simplistic to regard this as the view of all local representatives of the medical profession. Both the Durham County Executive Council (8.39) and the County Medical Officer stressed the value of locally available consultative facilities in attracting high quality GPs to Washington (8.40), paralleling the view advanced in respect of Peterlee that a similar development was necessary to lessen the area's dependence on overseas doctors. Thus the possibility of experimental forms of health service provision continued to be explored and the importance of such facilities was persistently stressed by the NTDC(8.41). While the RHB reiterated that full-scale hospital development in Washington was out of the question for at least 15 years (8.42), therefore, they continued to investigate alternative ways of providing hospital services in Washington (8.43). However, with the proposals of the Bonham-Carter Report (Central Health Services Council, 1969; see Chapter 6) which advocated a spatial concentration of hospital facilities into units of 1,000 or more beds, it became clear that Washington (and indeed Peterlee) would not be considered seriously as a site for development on such a scale. Moreover, given the uncertain climate in which NHS planning was taking place in the late 1960s, due to the
possibility of NHS reorganisation, it is perhaps not surprising that the form to be taken by health services in Peterlee and Washington was not an issue for extensive public debate.

In concluding this section, themes common to hospital planning for the new towns of Peterlee and Washington are drawn together; theoretical issues will be considered in the conclusion to this chapter. Firstly, NHS planners are dependent on the population of the new town reaching a certain level before services are provided. In both these cases a persistent problem for the RHB was uncertainty as to whether these towns would attain their target populations. There exist no statutory mechanisms to ensure that health services are provided in advance of full demand in new towns. Moreover, the NTDCs are not in a position to guarantee that new towns will achieve specified population targets; though they can provide both the basic infrastructure for industrial development, as well as housing, ultimately they are dependent on the decisions of both entrepreneurs (on industrial location) and individuals (migration to the town) as to whether or not the anticipated development takes place.

Furthermore, land-use allocation decisions have posed problems for health authorities. Thus, at Peterlee, site availability was delayed due to a prior agreement on coal extraction between the NCB and the NTDC (though in fact resource constraints seriously limited what the RHB could achieve in any case), while in Washington the central site requested by the RHB was not made available, though, again, the RHB were willing to develop an alternative site. In general, NTDCs cannot be seen to leave large areas of land undeveloped for considerable periods especially when the possibility of other development
(such as housing, in the Peterlee case) exists. Given the constraints on the RHB's capital investment programme, then, it is not surprising that references were made by the NTDCs to 'sterilising' land (Washington) or 'leaving an undeveloped hole' (Peterlee).

Finally, whatever the good intentions of health authorities, they are constrained not only by the planning problems outlined here but also by the amount of resources available at any one time for capital development, and by medical opinion on what kind of facilities are appropriate; the discussions on the merits (or otherwise) of providing hospital facilities from a health centre in Washington clearly illustrate this.

The foregoing evidence, then, has illustrated the problems posed for the Newcastle RHB by the decisions to locate new towns at Washington and Peterlee. The question of whether or not to develop hospital facilities in these locations resurfaced in the late 1970s and aspects of the ensuing discussions are presented in Chapters 9 and 10. A further major issue in intra-regional spatial policy is that of the urban redevelopment of Newcastle as a 'regional capital'. The links between this and hospital planning are now examined.

8.4 Urban redevelopment and hospital planning in Newcastle upon Tyne.

As noted above (section 8.2) an important theme in intra-regional spatial policy in North East England has been the assertion that development must necessarily proceed unevenly within the region. It is evident that Newcastle was seen as a regional capital by a number of prominent local politicians. This can be linked to hospital planning, for there existed a consensus view among a variety of local politicians, planners
and medical professionals that a centralised development of hospital facilities in Newcastle was necessary. Here an attempt is made to elucidate the connections between hospital planning and the intended redevelopment of Newcastle.

A persistent theme in hospital development in the Newcastle RHB area was the view that the future hospital services of North East England should be planned around a major medical complex in Newcastle. This theme can be traced at least to wartime negotiations between several voluntary hospitals in Newcastle (8.44). Following these discussions, the Hospital Surveys proposed the development of a Hospital Centre in the city, which would be achieved by coordinating the facilities of the RVI and six specialist hospitals. If this could be coordinated successfully with that of NGH, to prevent overlapping and duplication of services, Newcastle's position as a medical centre would be greatly enhanced (Ministry of Health, 1946 (volume 10), 10, 14, 51, 52). Implicit in this proposal was the view that the Centre would dominate the region's hospital services (Ministry of Health, 1946 (volume 10), 10, 14, 51). Indeed Newcastle's hospitals were intended to serve a population over three times as great as that of the next largest hospital district (table 8.2). However, the immediate effect of such proposals in the early postwar years was minimal. The resources available for development were so limited (see Chapter 5) that the Hospital Centre project had to be 'shelved indefinitely' (8.45). Under the 1946 NHS Act, responsibility for Newcastle's hospital services was divided between the RHB and BG. However, not until 1955 were formal steps taken to coordinate development plans for the Hospital Centre (8.46).

The concept of Newcastle as a medical capital was reaffirmed
Table 8.2  Proposed populations of hospital districts in North East England.

<table>
<thead>
<tr>
<th>District</th>
<th>Population (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newcastle (2)</td>
<td>1,243,699</td>
</tr>
<tr>
<td>Sunderland</td>
<td>357,590</td>
</tr>
<tr>
<td>Middlesbrough</td>
<td>359,536</td>
</tr>
<tr>
<td>Darlington</td>
<td>169,985</td>
</tr>
<tr>
<td>Durham</td>
<td>288,211</td>
</tr>
</tbody>
</table>

Source: Ministry of Health, 1946 (volume 10).

Notes:
1. Dates to which these refer were not given; nor were the criteria on which they were assessed.
2. This district includes Tyneside with Tynemouth, South Shields and Gateshead, Northumberland, and that part of County Durham lying south-west of Newcastle, down to Consett and Chester-le-Street.
in the Hospital Plan (Ministry of Health, 1962, 17) and extensive negotiations subsequently took place on future hospital developments in the city. While the RHB and the BG agreed on the necessity to accord these developments some priority over the rest of the region (8.47), differences of opinion emerged over the most appropriate way to achieve this. Briefly, the RHB favoured developing three general hospitals - the RVI, NGH and Freeman Road - but considerable opposition developed. According to a group of prominent doctors at NGH, such a scheme was wasteful, disruptive and duplicative of services. By contrast, their plans for developing the RVI, NGH and a new hospital in between these two sites, would provide:

'a unified medical precinct bringing together all the major regional units to give a complex worthy of the fine traditions of Newcastle medicine'.

(8.48)

Such a complex could become 'a model of hospital development in the country (8.49). Thus the image of Newcastle as a leading medical centre was invoked as a partial justification for the consultant lobby's arguments, though their case stressed several other factors, particularly the detrimental consequences for medical education of building Freeman Road Hospital. Their proposals were also favoured by the City Council, some prominent local politicians (especially T. Dan Smith - 8.50) and representatives of Newcastle University. Crossman (8.51) argues that the Council required the Freeman Road site for housing (8.52) but it is evident that they shared some common ground with the consultant lobby in terms of their views on the redevelopment of Newcastle. Both parties saw the necessity for the city to be developed as a regional and medical capital. This ideology was actively propounded by key
individuals in the Freeman Road debate. T. Dan Smith, in particular, was a keen supporter of proposals for a centralised development of services, and at a time (mid-1969) when the dispute seemed intractable, he exerted pressure for direct ministerial intervention. Thus Crossman, somewhat wryly, describes an exchange with:

'T. Dan Smith... the big boss of the North East... (who) was full of his concept that the hospitals must help in the export trade and must provide a base for Newcastle's industry'.

(Crossman, 1976, 589 - emphases added)

Implicit in such a statement was Smith's acceptance of the view that modernisation of Newcastle's infrastructure was a necessary prerequisite for its role in industrial development. Crossman went on to argue that while such an objective would be facilitated by a large scale centralised development, locating a third general hospital on the edge of the city 'would not totally upset that' (Crossman, 1976, 589).

In addition to Smith, the City Council supported the proposals for a centralised medical complex. The following quotes, from the Leader of the City Council, Alderman Arthur Grey, are indicative of their views:

'as Newcastle was the regional capital, which already had an expanding university, the idea of a large hospital complex was a very attractive proposition'

(8.53)

'we already have in the centre of Newcastle a fine civic centre precinct and university precinct, and we could have a medical complex there as well'.

(8.54)

Given the aim of developing Newcastle as a regional capital (on which see Burns, 1967; and section 8.2 above), it is not surprising that the City Council favoured proposals to concentrate hospital services in the city centre. There are,
of course, economic and medical reasons for centralisation, but the factors stressed here refer not to such considerations but rather to a shared view that the city of Newcastle ought to be developed as a regional and medical capital. This implied concentrating services on the RVI and an adjacent site. This argument is supported by the emphasis in both the Hospital Survey (Ministry of Health, 1946, 14) and the Hospital Plan (Ministry of Health, 1962, 17) on the key role of Newcastle in developing the region's hospital services. In addition, the consultant lobby had persistently stressed the potential for a medical complex which would be 'a model of hospital development in the country as a whole' (8.55). The view of Henry Miller (8.56) is perhaps the clearest indication of the convergence of the consultant lobby and the local planners and politicians:

'if we built a third hospital near the RVI, we would be setting a pattern for the future. We would have potentially the finest medical centre in Europe, with three closely integrated hospitals'.

(8.57)

In order to facilitate such a development, the City Council were willing to explore the potential availability of central sites, such as those at Barrack Road and Castle Leazes (8.58).

Finally, a point which should not be overlooked is that the RHB favoured according the 'highest priority' to the development of Newcastle's hospital services (8.59), but they felt that this would best be achieved by developing the Freeman Road site. The major point at issue here, then, is the convergence of the interests of the City Council, the university, the consultant lobby at NGH, and certain prominent local
politicians, on a proposal for centralised development which held up the implementation of the RHB's plans for some considerable time. This proposal was motivated not simply by considerations of efficiency (whether medical or economic), but also by a common wish to see Newcastle redeveloped as a regional and medical capital. The opposition to Freeman Road can thus partly be explained in terms of the convergence of these intentions, and it is evident that the ideology then dominant in intra-regional spatial policy was crucial in ensuring the support of certain non-medical agencies and politicians. Clearly other considerations (such as the claims advanced for centralisation on the grounds that it was in the interests of modern medical practice - Chapter 9) were important, but on the basis of the foregoing evidence it would be oversimplistic to account for the opposition to Freeman Road in these terms.

8.5 Concluding comments

This chapter began by outlining important themes in spatial policy in postwar North East England (section 8.2). Such policies led to problems for hospital planning, particularly those posed by new town development (section 8.3) and a certain convergence of intentions was evident in proposals for hospital planning in Newcastle. Some conclusions are now drawn concerning state practice.

Firstly, the scope for manoeuvre of state agencies is constrained by several factors, irrespective of the intentions of the agencies concerned. Although the RHB were in favour of hospital development at Peterlee, their capital allocation was insufficient to permit this being implemented, due to restraint of NHS expenditure resulting from a variety of socio-political
pressures on central government (Chapter 5). By the 1960s, with the shift in emphasis of hospital policy towards the DGH concept (Chapter 6), Peterlee and Washington could not seriously be considered as potential hospital sites due to their small populations. More flexible approaches to health care delivery were therefore attempted.

Secondly, though the foregoing evidence could be taken as lending only partial support for Offe's views on the selective nature of the capitalist state, it is important to note the role of ideology in the Newcastle dispute. The ideology of modernisation of the urban environment had a considerable influence on attitudes to hospital provision. While there was basically agreement that Newcastle's hospital facilities should be accorded priority over the rest of the region, a divergence of opinion on how best to achieve this held up planning for some seven years. This can partially be accounted for by the coincidence of interests of several politicians and medical personnel, all of whom favoured a major centralised development in the city.

Thirdly, the divergent policy intentions of various state agencies forms a further important theme. In both Peterlee and Washington, differences of opinion as to the most appropriate hospital site resulted from the divergent objectives being pursued by various agencies. Thus the NCB's requirement to maximise coal production delayed the availability of a proposed site at Peterlee. Likewise the resource constraints on the RHB, which led to further delays, exposed the RHB to the charge that their policy was at variance with the aim of developing Peterlee as a focus for service provision in the Easington area, because of the continued existence of other facilities in the locality.
References by NTDCs to 'sterilising' land and leaving 'undeveloped holes' in the centre of their towns, exemplify the problems of developing social facilities in such centres. NTDCs cannot be seen to leave land undeveloped, yet they are largely dependent on the decisions of various agencies concerning service provision. Moreover, in both cases the RHB was concerned that the anticipated population growth would not materialise. Yet NTDCs are not in a position to guarantee such growth since they are largely dependent on voluntary migration which, in turn, was dependent on the availability of employment opportunities and so on private sector investment decisions.

To summarise, then, it is evident, that the problems of hospital planning discussed here cannot be understood outside the broader context of developments in intra-regional spatial policy in North East England. New town development, and the proposals for modernising Newcastle's urban environment, both influenced the strategies put forward and created problems for NHS planners. Attempts to resolve such problems now receive further consideration in Chapter 9.
Footnotes

8.1 Notes of a meeting between the RHB's architect and officials of Peterlee NTDC, 23.12.49 - held in RHB 47/A.

8.2 Newcastle RHB (1950) First Report, p.10; see also Chapter 5.

8.3 Letter from the RHB to the Ministry of Health, 4.9.51 - held in RHB 47.

8.4 Notes of a meeting between representatives of the RHB and Peterlee NTDC, 19.3.52 - held in RHB 47/A.

8.5 RHB file note, 12.10.53 - held in RHB 47/A.

8.6 Letter from the NTDC to the RHB, 2.3.54 - held in RHB 47/A.

8.7 RHB file note, 7.9.54 - held in RHB 47/A.

8.8 Internal memorandum by the Senior Administrative Medical Officer, Newcastle RHB, 18.6.57 - held in RHB 47/A. See also Chapter 5.

8.9 Notes of a meeting between representatives of the RHB and Peterlee NTDC, 3.12.59 - held in RHB 47/A.

8.10 Ibid.

8.11 Ibid.

8.12 Letter from Peterlee NTDC to the RHB, 20.1.60 - held in RHB 47/A.

8.13 Notes of a meeting between representatives of Peterlee NTDC and the RHB, 11.5.60 - held in RHB 47/A.

8.14 RHB report entitled Hospital Provision for Peterlee NewTown: Population Changes and Local travel facilities in the area, 16.12.60 - held in RHB 47/A.

8.15 RHB note on Hospital Services for Peterlee NewTown, 10.2.61 - held in RHB 47/A.

8.16 RHB note of a meeting between the Assistant Senior Administrative Medical Officer (Newcastle RHB) and the NTDC 24.11.61; this document anticipated such pressure and indeed this point was the subject of correspondence between the RHB and local interest groups in the early 1960s - correspondence held in RHB 47/A.
Notes of a meeting between RHB officials and Peterlee GPs, on hospital facilities in Peterlee, 9.3.66 - held in RHB 47/A.

Discussed in RHB internal memoranda dated 8.7.68 and 14.7.69 - held in RHB 47/A.

RHB file note (n.d., probably early 1961) on Sunderland HMC: population served and hospital facilities provided, including future population trends - held in RHB 195/E.

Minutes of meetings of the Special Joint Committee of Sunderland HMC and the RHB, 14.7.61, and of the HMC's Joint Medical Planning Committee, 1.3.62, both confirm this policy (documents held in RHB 195/E).

RHB paper on proposals for the development of hospitals in the Sunderland Group, 19.5.64 - held in RHB 195/E.

Letter from the Ministry of Health to the RHB, 9.7.64 - held in RHB 195/E.

Meetings between the RHB and (1) Sunderland Borough Council, 17.7.64 and (2) Durham County Planning Department, 4.9.64 - minutes held in RHB 195/E.

RHB officer meeting to discuss the site for a third DGH in the Sunderland area, 1.10.64 - held in RHB 195/E.

RHB note on Development of Hospital Services in the Sunderland area: sites for a district general hospital, 25.11.64 - held in RHB 195/E.

Ibid.

RHB Capital Development Sub-Committee meeting, 8.1.65.

Notes of an informal meeting at Washington NTDC, 3.8.65 - held in RHB 47/B.

Newcastle RHB - comments on Washington NTDC Master Plan, 26.1.67 - held in RHB 47/B.

Ibid.

RHB file note on the site of a future general hospital within Washington New Town (n.d., probably early 1967) - held in RHB 47/B.
8.32 Notes of a meeting between the RHB and Washington NTDC, 15.2.66 - held in RHB 47/B.

8.33 Washington NTDC, Health Services Committee meeting, 21.9.66 - copy held in RHB 47/B.

8.34 RHB Regional Officer Meeting, 26.11.66 - held in RHB 47/B.

8.35 RHB Internal memorandum (n.d. late 1966?) - held in RHB 47/B.

8.36 Officers of the RHB had visited the new community of Thamesmead early in 1967 to examine schemes for health service provision and consider their implications for Washington - a report on this visit was held in RHB 47/B.

8.37 RHB file note on Development of Health Services in Washington New Town, 5.7.67 - held in RHB 47/B.

8.38 Report of the Local Medical Advisory Committee, submitted to the meeting of the RHB's planning committee, 16.10.67 - held in RHB 47/B.

8.39 This body administered the Family Practitioner Service (GP), prior to NHS reorganisation in 1974.

8.40 RHB paper entitled Development of Health Services in Washington New Town: report of the Senior Administrative Officer and Secretary, 13.7.67 - held in RHB 47/B.

8.41 Ibid.

8.42 Ibid.

8.43 This issue was discussed by a Draft Report on Hospital Facilities in Washington New Town's Health Centres (n.d. - probably mid 1968) and a report to the RHB's Planning Committee, 10.7.68, both discussed this issue - documents held in RHB 47/B.

8.44 See Tyne Wear Archives Department, deposits 672/151 (Board of Governors of the United Newcastle Hospitals Reorganisation Committee) and 672/196. (Minute book of the Hospital Centre Committee, 1933-45). See also Chapter 4.


8.46 Note of matters discussed at a meeting of the joint committee of the RHB and the United Newcastle upon Tyne Teaching Hospitals, 27.1.55 - held in RHB/195.
Meeting between the RHB and the BG, 2.10.63, on Newcastle Hospital Centre: policy for development - held in RHB 195.

Memorandum by consultants at NGH to the RHB on the development of hospital services in Newcastle HMC (n.d., probably July 1967) - held in RHB 195.

Report of a meeting between the RHB and the consultants at NGH, 28.7.67 - held in RHB 195.

Chairman of the Northern Economic Planning Committee, 1965-1970. In this capacity, and as a City Councillor, Smith became involved in this dispute. His autobiography does not refer to the Freeman Road discussions except in mentioning Smith's desire to see 'a physical link' between NGH and Newcastle's Medical School (Smith, T.D., 1970, 148).

In his capacity as Minister of State at the DHSS, 1968-1970 Crossman became involved in the negotiations on the Freeman Road dispute and a detailed account of his role (as he saw it) is available in his Diaries (Crossman, 1976, (volume III), 589, 656-659).

Noting the support of the City Council, Crossman commented thus:
'their (the Council's) planner was convinced that the University was the right place, and they were also friends of Richardson (one of the leading consultants at NGH-JFM) so they had come in with a bang on the Vice Chancellor's side (i.e. in favour of the consultant lobby's proposals - JFM)'.
(Crossman, 1976, (volume III), 658).

Notes of a meeting between the RHB and the Planning Committee of Newcastle City Council, 25.7.69 - held in RHB 195.

Reported in the Newcastle Journal, 31.7.69 - emphases added.

See notes 8.48 and 8.49.

Professor of Neurology at Newcastle University, 1964-1968; Dean of Medicine, 1966-1968; Vice-Chancellor, 1968-1976. See Miller (1973) for his views on hospital planning.

Reported in the Newcastle Journal, 28.7.69 - emphases added.
8.58 Notes of a meeting between the RHB and the Planning Committee of Newcastle City Council, 25.7.69 - held in RHB 195.

8.59 RHB document, Planning of the Newcastle Medical Centre: Report of Chief Officers, 28.5.69 - held in RHB 195.

9.1 Introduction

The intention here is to show how attempts have been made to resolve hospital planning disputes either in terms of allegedly neutral techniques or by presenting a 'model' of hospital provision as being in everyone's best interests. Thus section 9.2 summarises studies produced on behalf of Durham AHA and by the Northern RHA to justify their respective proposals for hospital development in the Durham Health District. Discussion of the limited value of location-allocation methods in planning emphasises the limitations of certain approaches to public facility location problems (see Chapter 2). Section 9.3 demonstrates how a group of prominent medical professionals in Newcastle sought to legitimate their intentions for the city's hospitals as being in the best interests of all concerned. Following this, section 9.4 considers studies of alternative strategies for hospital provision in Sunderland AHA. Finally, section 9.5 draws together the common themes and implications of these studies.

9.2 Hospital location in the Durham Health District

This section summarises a report prepared for Durham AHA during 1979. This had been commissioned on the understanding that it was to be employed in assessing alternative hospital strategies in the Durham Health District (see figure 9.1). Following a brief review of the historical background to this case (section 9.2.1) the report itself is summarised (section 9.2.2), its technical limitations are pointed out (section 9.2.3)
Figure 9.1: The Durham Health District

Source: Durham AHA (1979)
and finally the use to which it was put is discussed (section 9.2.4).

9.2.1. Background

It was shown above (Chapter 8) that the development of Peterlee New Town had posed problems for health service planning since its designation. The issue of hospital provision for this area reappeared on the political agenda in the late 1970s, for three reasons.

Firstly, the 1974 NHS reorganisation had created AHAs and RHAs (see Appendix 1) whose functions, it may be argued, were potentially conflicting. AHAs were charged with providing a service for their resident population, while the RHA's responsibility was essentially to ensure efficient strategic planning; hence total self-sufficiency at AHA level was not seen as essential by the Northern RHA (Newcastle AHA(T), 1977,4). This is not to suggest that policy conflicts between RHAs and AHAs necessarily followed from the functions with which they were charged; rather, a situation had been created in which conflicting strategies within the NHS could come into opposition.

Secondly, schemes had emerged for a rather smaller scale of hospital provision, prompted by the accessibility and public expenditure implications of DGH development (see Chapters 6 and 7). Whereas Peterlee could not be considered as a potential DGH site, these developments once again raised the possibility of providing a hospital in the Peterlee area.

Thirdly, the Durham AHA was in the process of reviewing its hospital strategy. From the Hospital Plan onwards, it had been assumed that central Durham's acute hospital facilities would be concentrated in Durham City, either at Dryburn Hospital or on a new site (9.1). However, the formal allocation of the
population of Easington District to Durham AHA following the 1974 NHS reorganisation (due to the requirement for coterminosity of AHA and local authority district boundaries) meant that the AHA was required to plan to serve an increased population, of around 240,000. Furthermore, the necessary beds could not all be accommodated at Dryburn, due to restrictions on both horizontal expansion (the site was a limited one) and vertical site development (9.2). Consequently the AHA considered several alternatives.

The Authority were concerned at the lack of local hospital facilities for approximately 105,000 people resident in Easington local government district. The only locally-sited hospital was Thorpe Maternity, near Easington. However, this was administered by Sunderland AHA who, it was thought, were unwilling to maintain it. If the hospital were therefore to close, the Easington area would be deprived of maternity facilities and new construction would be necessary to replace this, and this could not be accommodated at Dryburn (Durham AHA, 1974, 41). The Durham AHA's concern at the lack of local hospital facilities was also prompted by socio-economic conditions in the Easington area. In particular, a high proportion of the district's population was in 'deprived' categories (table 9.1), and projected population changes within the Durham AHA, especially in the numbers of people aged over 65 and of pre-school children, were likely to be greatest in the Easington district (table 9.2). After considering various strategic options, the AHA favoured developing a general hospital in Peterlee, to complement the DGH at Dryburn. This would provide local specialist and maternity services in the Easington area, and would avoid the problems inherent in attempting to pack a
Table 9.1 Distribution of 'deprived' populations by type of deprivation and by local government districts within Durham AHA

<table>
<thead>
<tr>
<th>Types of Deprivation (AHA's classification)</th>
<th>Darlington</th>
<th>Teesdale</th>
<th>Durham</th>
<th>Chester-le-St</th>
<th>Easington</th>
<th>Derwentside</th>
<th>Wear Valley</th>
<th>Sedgefield</th>
<th>Totals for Co. Durham</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple deprivation 'inner city' type and poor council estates on the periphery of urban areas with similar deprivation.</td>
<td>3045</td>
<td>-</td>
<td>7245</td>
<td>1460</td>
<td>-</td>
<td>-</td>
<td>9160</td>
<td>-</td>
<td>20920</td>
</tr>
<tr>
<td>Concentration of potentially disadvantaged persons in old mining villages - not as severe as above.</td>
<td>5675</td>
<td>-</td>
<td>1985</td>
<td>1435</td>
<td>15915</td>
<td>12625</td>
<td>8470</td>
<td>735</td>
<td>46840</td>
</tr>
<tr>
<td>Working class areas with an aging population, low socio-economic status, but no extreme deprivation.</td>
<td>-</td>
<td>-</td>
<td>24535</td>
<td>12645</td>
<td>49590</td>
<td>25195</td>
<td>11615</td>
<td>875</td>
<td>124455</td>
</tr>
<tr>
<td>Total population categorised as deprived.</td>
<td>8720</td>
<td>-</td>
<td>33775</td>
<td>15540</td>
<td>65505</td>
<td>37820</td>
<td>29245</td>
<td>1610</td>
<td>192215</td>
</tr>
<tr>
<td>Deprived population as a percentage of total residential population in 1978.</td>
<td>8.9%</td>
<td>40.4%</td>
<td>31.2%</td>
<td>62.3%</td>
<td>41.4%</td>
<td>45.4%</td>
<td>1.7%</td>
<td>31.6%</td>
<td></td>
</tr>
</tbody>
</table>

Table 9.2  Projected population changes 1976-1988, by health district, local government district, and age group.

<table>
<thead>
<tr>
<th>Health District</th>
<th>Local Government District</th>
<th>Populations and Changes</th>
<th>0-4</th>
<th>5-14</th>
<th>15-29</th>
<th>30-44</th>
<th>45-64</th>
<th>65-74</th>
<th>75+</th>
<th>Totals (All ages)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Darlington</td>
<td>Darlington</td>
<td>No.</td>
<td>+602</td>
<td>-3766</td>
<td>+1535</td>
<td>+2053</td>
<td>-1456</td>
<td>-497</td>
<td>+1091</td>
<td>-438</td>
</tr>
<tr>
<td></td>
<td></td>
<td>%</td>
<td>+9.6</td>
<td>-23.7</td>
<td>+7.6</td>
<td>+11.9</td>
<td>-6.1</td>
<td>-5.5</td>
<td>+22.0</td>
<td>-0.5</td>
</tr>
<tr>
<td>Darlington</td>
<td>Teesdale</td>
<td>No.</td>
<td>-19</td>
<td>-828</td>
<td>+128</td>
<td>+73</td>
<td>-391</td>
<td>+99</td>
<td>+724</td>
<td>-214</td>
</tr>
<tr>
<td></td>
<td></td>
<td>%</td>
<td>-1.3</td>
<td>-25.3</td>
<td>+2.8</td>
<td>+1.9</td>
<td>-6.3</td>
<td>-3.5</td>
<td>+45.4</td>
<td>+0.9</td>
</tr>
<tr>
<td>Durham</td>
<td>Durham</td>
<td>No.</td>
<td>+253</td>
<td>-3188</td>
<td>+1383</td>
<td>+1990</td>
<td>+91</td>
<td>-162</td>
<td>+928</td>
<td>+1295</td>
</tr>
<tr>
<td></td>
<td></td>
<td>%</td>
<td>+4.6</td>
<td>-23.4</td>
<td>+7.4</td>
<td>+12.3</td>
<td>+0.5</td>
<td>-2.3</td>
<td>+26.0</td>
<td>+1.6</td>
</tr>
<tr>
<td>Durham</td>
<td>Chester-le Street</td>
<td>No.</td>
<td>+136</td>
<td>-2609</td>
<td>+1637</td>
<td>+267</td>
<td>+365</td>
<td>-427</td>
<td>+455</td>
<td>-176</td>
</tr>
<tr>
<td></td>
<td></td>
<td>%</td>
<td>+4.1</td>
<td>-30.5</td>
<td>+16.4</td>
<td>+2.5</td>
<td>+3.3</td>
<td>-10.2</td>
<td>+22.6</td>
<td>-0.4</td>
</tr>
<tr>
<td>Durham</td>
<td>Easington</td>
<td>No.</td>
<td>+1194</td>
<td>-5081</td>
<td>+1225</td>
<td>+531</td>
<td>-751</td>
<td>-364</td>
<td>+1581</td>
<td>-1665</td>
</tr>
<tr>
<td></td>
<td></td>
<td>%</td>
<td>+17.6</td>
<td>-28.5</td>
<td>+5.1</td>
<td>+3.1</td>
<td>-3.0</td>
<td>-3.7</td>
<td>+35.1</td>
<td>-1.6</td>
</tr>
<tr>
<td>N.W.Durham</td>
<td>Derwentside</td>
<td>No.</td>
<td>+355</td>
<td>-3630</td>
<td>+1184</td>
<td>+1134</td>
<td>-2307</td>
<td>-859</td>
<td>+1275</td>
<td>-2848</td>
</tr>
<tr>
<td></td>
<td></td>
<td>%</td>
<td>+6.3</td>
<td>-25.3</td>
<td>+6.2</td>
<td>+7.2</td>
<td>-10.3</td>
<td>-9.2</td>
<td>+27.6</td>
<td>+3.1</td>
</tr>
<tr>
<td>S.W.Durham</td>
<td>Wear Valley</td>
<td>No.</td>
<td>+511</td>
<td>-2621</td>
<td>+464</td>
<td>+1440</td>
<td>-2156</td>
<td>-466</td>
<td>+464</td>
<td>-2364</td>
</tr>
<tr>
<td></td>
<td></td>
<td>%</td>
<td>+13.0</td>
<td>-25.9</td>
<td>+3.4</td>
<td>+13.5</td>
<td>-13.3</td>
<td>-7.3</td>
<td>+13.6</td>
<td>-3.7</td>
</tr>
<tr>
<td>S.W.Durham</td>
<td>Sedgefield</td>
<td>No.</td>
<td>+1340</td>
<td>-3399</td>
<td>+2622</td>
<td>+3950</td>
<td>-885</td>
<td>-106</td>
<td>+412</td>
<td>+3934</td>
</tr>
<tr>
<td></td>
<td></td>
<td>%</td>
<td>+21.6</td>
<td>-21.8</td>
<td>+12.0</td>
<td>+24.0</td>
<td>-4.0</td>
<td>-1.5</td>
<td>+12.2</td>
<td>+4.2</td>
</tr>
<tr>
<td>Durham AHA</td>
<td></td>
<td>No.</td>
<td>+4372</td>
<td>-25122</td>
<td>+10178</td>
<td>+11438</td>
<td>-7490</td>
<td>-2782</td>
<td>+6930</td>
<td>-2476</td>
</tr>
<tr>
<td></td>
<td></td>
<td>%</td>
<td>+11.1</td>
<td>-25.5</td>
<td>+7.7</td>
<td>+10.6</td>
<td>-5.1</td>
<td>-5.0</td>
<td>+24.7</td>
<td>-0.4</td>
</tr>
</tbody>
</table>

Source:
large numbers of beds onto the Dryburn site (Durham AHA, 1971, 41-42).

These proposals were, however, rejected by the Northern RHA, because:

'(this strategy) is not considered to be in the best interests of the people involved, and would result in an uneconomic arrangement involving three general hospitals (Durham, Peterlee and Hartlepool) close together but each so small as to call into question their viability and their recognition from the point of view of professional training... accessibility by public or private transport would, overall, be worse to Peterlee and/or Durham than to Sunderland for those living in the North and to Hartlepool for those living in the South'.

(Northern RHA, 1979, 36-37).

The RHA's preference was for the redevelopment of Dryburn Hospital; services for the Easington District would then be provided by continuing reliance on DGHs in Hartlepool and Sunderland. The conflicting objectives made explicit in the above document led the AHA to commission the work reported in the next section to aid their assessment of the options open to them.

9.2.2 Location-allocation analysis of alternative hospital strategies for the Durham Health District.

Against the background of the dispute reported in the previous section, the AHA commissioned the work reported here. The brief for the project was relatively straightforward...Given the AHA's assumptions about the nature and distribution of demand for hospital services, what would be the optimum location of services to meet this demand? Research involved three stages. Firstly, the study area was defined, using data on the likely areas of origin of patients; secondly, an assessment was made of the adequacy of current hospital provision; and thirdly,
an analysis was undertaken of the optimum location(s) of hospital services within the study area.

The area under consideration was the Durham Health District of Durham AHA (see figure 9.1). However, there was clear evidence of cross-boundary patient flows in both directions; discussions with AHA officials (9.3) supported by planning documentation (9.4) suggested that three cross-boundary flows were of particular importance. Firstly, the Browney Valley - up to and including Lanchester - was technically part of North West Durham Health District, but the AHA accepted that this fell within the catchment area of Durham's hospitals. Secondly, there was evidence of travel to hospitals in the Durham AHA from the area immediately north of Chester-le-Street. Finally, although Seaham was included in the Durham Health District, it is so close to Sunderland that its population is almost entirely served by hospitals there. Building on these guidelines, the AHA's intention was to serve populations from various local authorities as shown in table 9.3. As indicated above, the Lanchester area would be served by Durham hospitals, while the Seaham area would be allocated to Sunderland. Secondly, certain small cross-boundary flows into the district - in particular, from Gateshead AHA and South West Durham Health District - were to be eliminated (9.5). Thirdly, it was felt that links between Durham hospitals and Peterlee were being strengthened (9.6), which, coupled with the expansion of Peterlee, would result in 60% of the population of Easington District being served by Durham.

Therefore, acute hospital facilities in the Durham Health District would serve the local government districts
Table 9.3 Populations to be served by hospitals in the Durham Health District.

<table>
<thead>
<tr>
<th>Local Government District</th>
<th>Target Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Durham City</td>
<td>85,000</td>
</tr>
<tr>
<td>Chester-le-Street</td>
<td>48,000</td>
</tr>
<tr>
<td>Derwentside</td>
<td>7,000</td>
</tr>
<tr>
<td>Easington</td>
<td>60,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>200,000</strong></td>
</tr>
</tbody>
</table>


Table 9.4 Total provision of general hospitals in the study area, and needs for additional capacity

<table>
<thead>
<tr>
<th>Facility</th>
<th>Beds</th>
<th>Population Served</th>
<th>Shortfall</th>
<th>Additional Beds Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>General medicine</td>
<td>126.0</td>
<td>148,000</td>
<td>64,048</td>
<td>54</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>52.5</td>
<td>210,000</td>
<td>2,000</td>
<td>2</td>
</tr>
<tr>
<td>General surgery</td>
<td>103.1</td>
<td>171,800</td>
<td>40,250</td>
<td>24</td>
</tr>
<tr>
<td>Trauma/orthopaedics</td>
<td>79.0</td>
<td>225,000</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>32.0</td>
<td>128,000</td>
<td>84,000</td>
<td>21</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>54.2</td>
<td>112,400</td>
<td>100,000</td>
<td>48.2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>149.2</strong></td>
</tr>
</tbody>
</table>

Source: Durham AHA Health Information System Basic Tables.
of Durham and Chester-le-Street, and the Lanchester area of Derwentside. However, determining the precise location of demand within Easington District, was a less tractable problem.

While evident that the Seaham and Murton areas should be excluded from the study area, allocating demand between the Hartlepool and Durham Health Districts was more complex. In the absence of detailed information on patterns of patient flow in this area, the population was simply allocated on the basis of relative proximity to existing services in Durham and Hartlepool. The problems inherent in such a simplistic assessment were compounded by the difficulty of judging the effect on patient flow patterns of a hospital in the Peterlee area (see section 9.2.3 below). The area employed in the analysis is shown in figure 9.2, while figure 9.3 gives the population density of this area by 1km grid squares.

The second stage involved assessing the adequacy of existing hospital capacity and the requirement, if any, for additional facilities. The measure of 'demand' used was that of population in each 1km grid square; the total population to be served was 212,048 (9.7). This unsophisticated estimate of demand was justified on two grounds. Firstly, a uniform areal unit was essential for the computer program employed in the analysis and, secondly, total population was consistent with the NHS guidelines, or norms, for bed provision in relation to population. To assess the adequacy of the existing hospital capacity, the existing bed provision is compared with what would be predicted by the norms. This is summarised in table 9.4, which demonstrates a shortfall in capacity of approximately 150 acute beds and 22 geriatric beds. The final stage in the analysis was an assessment of where best to locate an additional
Figure 9.2: The Durham Health District, showing modifications to reflect patterns of patient flow.
Figure 9.3: Population density in the modified Durham Health District, by 1 km. grid squares
facility to meet this shortfall.

This involved the use of the TORNQUIST computer algorithm (Tornquist et al., 1971; Rushton, Goodchild and Ostresh, 1973), the value of which had been demonstrated in several analyses (e.g. Robertson, 1976; 1977; 1978). The technique involves minimising the aggregate travel function generated by providing m facilities to serve n demand points. Mathematically this can be stated thus:

\[
\text{minimise } c = \sum_{j=1}^m \sum_{i=1}^n p_i d_{ij}
\]

where \( c \) = total cost function

\( p_i \) = demand at point

\( d_{ij} \) = distance between demand point i and supply point j

Several more extensive and detailed reviews (Beaumont 1980; Eilon et al., 1971; Hodgart, 1978) and bibliographies (Freestone, 1977; Lea, 1973) are available on these methods, and so the mechanics of the procedure used are not discussed at greater length. The measures of demand and distance used were, respectively, total population in each 1km grid square, and straight line distance; the limitations of these are discussed below (section 9.2.3). Analysis then proceeded through an assessment of the aggregate travel function for the existing hospital sites (table 9.5.1) to a consideration of where best to locate an additional facility. It was shown that locating an additional hospital in Peterlee would reduce the aggregate travel function for the Durham Health District from 1,570,021 km to 794,306 km a reduction of 49% (table 9.5.2). In these terms it could be argued convincingly that access to hospital services in the Durham Health District would be greatly improved if a hospital were to be provided at Peterlee. An alternative strategy was also considered involving closure of the facilities
Table 9.5 Aggregate and average travel statistics for various combinations of hospital locations

9.5.1 The existing sites at Dryburn and Chester-le-Street.

<table>
<thead>
<tr>
<th>Location</th>
<th>Population Served</th>
<th>Aggregate Distance (km)</th>
<th>Average Distance (km)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dryburn</td>
<td>162,606</td>
<td>1,431,227</td>
<td>8.80</td>
</tr>
<tr>
<td>Chester-le-Street</td>
<td>49,442</td>
<td>138,794</td>
<td>2.80</td>
</tr>
<tr>
<td>Total</td>
<td>212,048</td>
<td>1,570,021</td>
<td>7.40</td>
</tr>
</tbody>
</table>

9.5.2 Three facilities: the two existing hospitals plus a third facility optimally located.

<table>
<thead>
<tr>
<th>Location</th>
<th>Population Served</th>
<th>Aggregate Distance (km)</th>
<th>Average Distance (km)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dryburn</td>
<td>98,194</td>
<td>457,905</td>
<td>4.76</td>
</tr>
<tr>
<td>Chester-le-Street</td>
<td>49,439</td>
<td>138,745</td>
<td>2.80</td>
</tr>
<tr>
<td>Optimal site for third facility</td>
<td>66,415</td>
<td>197,656</td>
<td>2.97</td>
</tr>
<tr>
<td>Total</td>
<td>212,048</td>
<td>794,306</td>
<td>3.74</td>
</tr>
</tbody>
</table>

9.5.3 Two facilities: one at Dryburn, the second optimally located.

<table>
<thead>
<tr>
<th>Location</th>
<th>Population Served</th>
<th>Aggregate Distance (km)</th>
<th>Average Distance (km)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dryburn</td>
<td>144,485</td>
<td>845,021</td>
<td>8.85</td>
</tr>
<tr>
<td>Optimal site for second facility</td>
<td>67,363</td>
<td>209,295</td>
<td>3.09</td>
</tr>
<tr>
<td>Total</td>
<td>212,048</td>
<td>1,053,316</td>
<td>4.97</td>
</tr>
</tbody>
</table>

Note:
1. In both cases the 'optimal site' referred to was in Peterlee New Town.
in Chester-le-Street and searching for the optimum location of a new facility, assuming, again, that Dryburn remained the major facility for the Durham Health District. This would reduce the aggregate distance function by 32.7%, from 1570021 km to 1054316 km (table 9.5.3). In terms of average travelling distances to each facility (see tables 9.5.1, 9.5.2, 9.5.3) the present arrangements give figures of 2.80 km to Chester-le-Street and 8.80 km to Dryburn. An additional facility at Peterlee would incur average travelling distances ranging from 4.76 km (Dryburn) to 2.97 km (Peterlee). Such a strategy therefore not only reduces the aggregate distance travelled to services, it also reduces the inequalities revealed by the range of average distances travelled, and therefore offers an improvement in terms of access to medical facilities.

To summarise, it was recommended that any new hospital development in the Durham Health District be located at Peterlee New Town; this would improve access to health care for the people of the Easington Local Government District, and it was likely that the effect upon patient flow would be such as to render the Durham Health District self-sufficient in hospital provision, since it would reduce cross-boundary patient flows. However, the latter is no more than plausible conjecture, given the problems of predicting the consequences of such a hospital development in terms of patient flows. Indeed this is indicative of some of the more general technical problems of such an exercise which are worthy of further discussion.

9.2.3 Limitations of the techniques employed
Technical problems of the research reported in the previous section relate to the measures of demand and distance
used, and also to the accuracy and appropriateness of the modelling procedure. As well as considering these issues, suggestions are put forward as to how the techniques employed could have been improved upon.

Clearly, a more accurate assessment could certainly have been made of demand for hospital facilities; total population is a very crude surrogate. Even though 1971 Census data permit disaggregation for particular social or age groups, this still involves some over generalisation for three reasons.

Firstly, class variation exists both in experience of ill-health and utilisation of health facilities; despite the existence of the NHS, these differentials have not been reduced (see DHSS, 1980b; Walters, 1980). Moreover, there exists convincing evidence that services are available in inverse relationship to need (expressed in terms of social conditions - see Hart, 1971; Knox, 1978; Phillips, 1979). Secondly, the spatial arrangement of services constrains the use that can be made of them (Haynes and Bentham, 1979); restrictions on the time and travel facilities available to individuals, whether as result of the public transport system or a consequence of domestic and employment duties, may inhibit service utilisation. Class-related differentials in mobility and employment may exacerbate such problems (Moseley, 1979), and settlement concentration policies may further compound them (Cloke, 1979). Finally, spatial and social variation in health status cannot be ignored, from the national and regional scale (Howe, 1963; 1972) and more locally (Young, 1972). Within the Northern RHA, the region's poor economic performance has been identified as 'detrimental' to the population's health (Northern RHA, 1979, 3), though unambiguous identification of the precise links between social conditions and ill-health is a complex
task (see DHSS, 1980b). For all these reasons, the use of simple population data as a basis for health service resource allocation must be treated with caution.

Concerning the measure of distance used, straight-line distance is clearly only a rough approximation, due to divergencies between such figures and actual road distance (Timbers, 1967). This had little effect on the work reported here however: the spatial concentration of population in three main centres means that any distance-minimising technique would tend to predict facility location in one of these centres irrespective of the measure of distance used. But straight-line distance over generalises in two other respects: it ignores the differential meaning of accessibility to different social groups (Dear, 1974), and it takes no account of variations in hospital utilisation behaviour (Hassan, 1974; Rigby, 1978).

Thus it is not disputed that this study could have been rather more sophisticated in terms of its data input, and that a more advanced modelling procedure could have been employed. For instance, Beaumont (1980), recommends the incorporation of spatial interaction concepts in order more realistically to represent facility user movement patterns. However, the crucial point to emphasise here concerns not the technical limitations of the work but rather the reasons for its commissioning, and the use to which it was put. This is now illustrated by reference to a dispute between the Durham AHA and the Northern RHA; in particular, the use of this study is contrasted with the use of a similar study carried out by the RHA.

9.2.4 The use of knowledge in planning: the dispute between the Northern RHA and Durham AHA.

In discussing this matter it is necessary to consider
briefly the study of hospital location in this area by the Northern RHA, before analysing the claims made for their respective studies by the RHA and the AHA.

The Northern RHA's evaluation of the spatial planning aspects of this issue had considered not only the Durham Health District, but also the presence of hospital facilities in adjacent districts which might be able to guarantee the necessary level of service provision for the Easington area (9.8). The RHA's study (9.9) commenced with a discussion of the implications of Durham AHA's proposals for hospital development in that area and in the adjoining Sunderland AHA and Hartlepool Health District. A new hospital at Peterlee could be expected to reduce patient flows into Sunderland AHA, thus reducing the population seeking services at Ryhope General Hospital. However the consequences for the Hartlepool Health District were more serious. The anticipated reduction in patient flow to Hartlepool could threaten the viability of some clinical units to the extent that they would not obtain a sufficient volume of work to gain the recognition of the Royal Colleges of Medicine for staff training purposes (9.10). Although general hospital facilities would be brought within easy reach of the population of the Easington area as a consequence of the AHA's proposals, the RHA felt that this point ought not to be over stressed, since the access problems imposed by existing arrangements were 'not excessive' (9.11). In support of this the RHA presented a study of distances from selected villages to hospitals (table 9.6) and of the availability of bus services in the Easington district (table 9.7). From these it could equally be claimed that providing a new hospital at Peterlee would, nevertheless, effect significant improvements in access to services. However the RHA remained
Table 9.6 NRHA analysis of distances to hospitals from selected centres in Easington Local Government district.

<table>
<thead>
<tr>
<th>From</th>
<th>Hartlepool General</th>
<th>Sunderland (Ryhope)</th>
<th>Sunderland (General)</th>
<th>Durham (Dryburn)</th>
<th>Peterlee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seaham</td>
<td>13.75</td>
<td>2.75</td>
<td>6.5</td>
<td>13.5</td>
<td>6.5</td>
</tr>
<tr>
<td>Murton</td>
<td>12.25</td>
<td>4.5</td>
<td>8.5</td>
<td>10.5</td>
<td>5.5</td>
</tr>
<tr>
<td>Easington</td>
<td>8.75</td>
<td>5.75</td>
<td>10.5</td>
<td>11.5</td>
<td>2.0</td>
</tr>
<tr>
<td>Easington Colliery</td>
<td>8.00</td>
<td>7.00</td>
<td>11.5</td>
<td>12.0</td>
<td>2.0</td>
</tr>
<tr>
<td>Horden</td>
<td>6.00</td>
<td>9.25</td>
<td>12.0</td>
<td>12.75</td>
<td>1.0</td>
</tr>
<tr>
<td>Peterlee</td>
<td>6.75</td>
<td>7.0</td>
<td>12.0</td>
<td>12.5</td>
<td>2.5</td>
</tr>
<tr>
<td>Shotton</td>
<td>9.5</td>
<td>9.0</td>
<td>12.0</td>
<td>9.5</td>
<td>2.5</td>
</tr>
<tr>
<td>Wingate</td>
<td>8.0</td>
<td>11.00</td>
<td>15.0</td>
<td>10.75</td>
<td>4.0</td>
</tr>
<tr>
<td>Blackhall</td>
<td>5.0</td>
<td>9.5</td>
<td>14.0</td>
<td>14.0</td>
<td>2.5</td>
</tr>
</tbody>
</table>

(Distances in miles)

Table 9.7 Public transport in Easington district: travel time and frequency of service from selected centres to existing hospitals.

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
<th>Hartlepool Frequency</th>
<th>Ryhope Frequency</th>
<th>Sunderland Frequency</th>
<th>Durham Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Time (minutes)</td>
<td>Time (minutes)</td>
<td>Time (minutes)</td>
<td>Time (minutes)</td>
</tr>
<tr>
<td>Seaham Harbour</td>
<td>Ryhope</td>
<td>1 15</td>
<td>4 12</td>
<td>4 20</td>
<td>1 55</td>
</tr>
<tr>
<td>New Seaham</td>
<td></td>
<td>2 50</td>
<td>8 6</td>
<td>8 15</td>
<td>1 40</td>
</tr>
<tr>
<td>Murton</td>
<td></td>
<td>- -</td>
<td>3 18</td>
<td>3 25</td>
<td>1 30</td>
</tr>
<tr>
<td>Easington</td>
<td></td>
<td>4 40</td>
<td>2 15</td>
<td>4 30</td>
<td>1 70</td>
</tr>
<tr>
<td>Easington Colliery</td>
<td></td>
<td>2 30</td>
<td>- -</td>
<td>2 38</td>
<td>1 60</td>
</tr>
<tr>
<td>Horden</td>
<td></td>
<td>3 25</td>
<td>- -</td>
<td>- -</td>
<td>3 60</td>
</tr>
<tr>
<td>Peterlee</td>
<td></td>
<td>5 35</td>
<td>2 30</td>
<td>3 35</td>
<td>5 50</td>
</tr>
<tr>
<td>Shotton</td>
<td></td>
<td>2 45</td>
<td>2 30</td>
<td>2 40</td>
<td>4 35</td>
</tr>
<tr>
<td>Wingate</td>
<td></td>
<td>2 25</td>
<td>1 35</td>
<td>1 45</td>
<td>1 55</td>
</tr>
<tr>
<td>Blackhall</td>
<td></td>
<td>7 18</td>
<td>- -</td>
<td>- -</td>
<td>2 55</td>
</tr>
</tbody>
</table>

Units Frequency - buses per hour
Time- minutes

Source:
convinced that the Easington district could still best be served by Hartlepool and Sunderland rather than by Durham AHA (9.12).

In considering the consequences of the studies reported here, the claims made for these studies by the RHA and AHA respectively are considered. The AHA felt that the work reported above (section 9.2.2) had vindicated their arguments, by confirming the strategy previously referred to - acute hospital provision in Peterlee and Durham, plus a community hospital in Chester-le-Street - as the 'optimum arrangement' of services (9.13). By contrast the RHA claimed that they had looked closely at 'the geography of and lines of communication within' the Easington area, and had concluded that this area could best be served from Hartlepool and Sunderland, rather than by Durham AHA (9.14). The crucial point here is not the objectivity and/or precision of the two studies, or the competence of those who conducted them, but rather the use to which they were put. Though both were somewhat innocuous pieces of research, the interests they were to serve meant that the analyses carried out supported the goals of the agencies on whose behalf they were produced. This begs the question of the extent of the dispute between these authorities (see Chapter 10), and raises the issue of the use of knowledge in planning, which will be examined more fully below (section 9.5).

9.3 Models of medical provision and hospital planning: the Freeman Road dispute.

The term model is employed in this context not in the sense of a simplified representation of reality but rather in the sense of an ideal type, a standard which can be presented as
being universally acceptable. In this sense it may be argued that a particular definition of the nature and scale of hospital provision was employed by a group of prominent medical staff at NGH, in order to present their views as being in the best interests of the future development of Newcastle's hospital services. A fuller account of the resolution of the dispute on hospital strategy is given below (Chapter 10). Here it is merely noted that, in opposition to the RHB's plans to develop a third DGH in Newcastle at Freeman Road, a group of medical staff at NGH proposed a major spatial concentration of services. This would be achieved by locating a new hospital in between the RVI and NGH; this proposal was actively supported by prominent local politicians (see Chapter 8). This section examines how such a scheme came to be presented as the most appropriate, or 'optimum', solution for the development of Newcastle's hospitals.

What follows has to be interpreted against the background of contemporary medical opinion on hospital size, which favoured a considerable spatial concentration of facilities in the interests of efficient medical practice. Such views received their clearest expression in the Bonham-Carter Report (Central Health Services Council, 1969), which argued for considerably larger hospitals than even the 1962 Hospital Plan. Despite the accessibility implications of such proposals, their supporters claimed that the superior quality of care to be provided would be in everyone's best interests.

Such views were evident in the proposals advocated by consultants at NGH in a submission to the Ministry of Health during 1966. They claimed that a third DGH in Newcastle would increase the difficulties of providing an adequate service for.
three reasons. Providing ancillary services on three sites would be inefficient; the development of medical education and practice would be facilitated by the concentration of services on two hospitals only; and a three-hospital scheme would lead to an unsatisfactory development of services which would be impossible to correct in the near future (9.15). Moreover, and in particular, the RHB's plans were considered to be insufficiently flexible to allow for changes in medical opinion (9.16). It was argued that medical opinion now favoured the development of hospital complexes of '2,000, 3,000 or even 5,000' beds, according to local circumstances (9.17). Finally, and perhaps most revealingly, it was claimed that if the Freeman Road scheme went ahead:

'the clinical confusion and inefficiency that will ensue will be a monument to our constricted vision that is now, and will continue to be, condemned by the whole concourse of informed medical and scientific opinion'

(9.18)

Clearly, therefore a view of medical practice was presented which emphasised the necessity for spatial concentration of services in the interests of clinical efficiency. This, in turn, was equated with, and presented as being in, the best interests of the recipients of the service. It also appears that such views were instrumental in gaining the support of certain prominent local politicians for these proposals. Such views may be absorbed readily, since the politicians concerned are not necessarily aware of the advantages and disadvantages of high technology, hospital-based medicine. Thus, Alderman A. Grey was quoted as follows:

'he (Ald.Grey) did not... understand the complexities of running a hospital, but he felt that if all the services could be together, it must surely be a better hospital'.
Likewise, Councillor B. Weeks asserted that:

'It is madness to have a hospital isolated from all the others in the way that Freeman Road will be. It seems to be against all the rules of modern medicine which call for concentrated complexes'.

(9.20)

Note, in the above quotes, the apparently unquestioned acceptance that 'big is beautiful' in terms of hospital provision, this being accorded the status of a 'rule' of modern medicine. Moreover, the access implications of such centralisation are presented as a necessary consequence of the provision of what is taken to be a superior hospital service. Thus Henry Miller (see note 8.56) claimed that 'Newcastle was a compact city which did not require suburban hospitals' and indeed, in his view, a central hospital complex was more accessible (9.21). In this he was supported by an editorial in the Newcastle Evening Chronicle which claimed that the overriding consideration was the establishment of:

'a really modern hospital and medical centre... the argument that Freeman Road hospital would be more convenient for patients and relatives in the eastern half of the city appeals, but not enough to sway the balance'.

(9.22)

Thus a view of hospital provision was presented which favoured centralisation of services in the interests of modern, efficient medical practice. This view appears to have carried some weight with local politicians and indeed with the press, so that the social implications of such proposals were either ignored or dismissed as being of only minor importance. Though a local MP emphasised the desirability of Freeman Road on social grounds (9.23), and though the RHB claimed that on such criteria they 'would have taken a great deal of shifting' from their plans (9.24), detailed examination of papers pertaining
to this debate shows that the social consequences of alternative schemes received little attention. Instead, discussion focused primarily on the arrangement of facilities that would best meet the interests of those responsible for the service. Furthermore, it will be argued below (Chapter 10) that perhaps the most important consideration, from the RHB's viewpoint was the interruption to their capital programme which would result if Freeman Road were not developed.

It seems, then, that in order to canvass support for proposals for a spatial concentration of Newcastle's hospital facilities, a group of prominent medical professionals justified their plans as being in the interests of efficient medical practice, this in turn being equated with the best interests of the people of Newcastle. From such a perspective, the accessibility implications of such developments and, more generally, the question of the appropriateness of the services being provided, received limited consideration. The theoretical implications of this evidence are taken up below; the next section discusses technical assessments of hospital location in Sunderland AHA.

9.4 Technical solutions to political problems: hospital strategy in Sunderland AHA.

As in the case of Peterlee, new town development at Washington posed some problems for NHS planners (Chapter 8). Resolution of these problems was attempted on purely technical criteria, and this section assesses this evaluation and its use in resolving the dispute.

The point at issue was whether the second DGH in Sunderland AHA should be located at Washington or Ryhope; the major
hospital in the area was to be Sunderland General (see Chapter 10 for fuller discussion and illustrations). The Washington and Ryhope sites were evaluated according to various criteria. On accessibility, Ryhope was claimed to be superior as it was only four miles from Sunderland General Hospital, whereas Washington was 5½ miles away. This assessment clearly ignored several criteria, such as the implications of accessibility for different social groups (Dear, 1974; Haynes and Bentham, 1979; White, 1979) and the characteristics of patient flow (Hassan, 19794; Rigby, 1978). Simply to base a comparison of the relative accessibility of the two sites on their distance from the major DGH in the AHA was to lay the RHA open to the charge of catering only for the needs of medical staff and administrators—an accusation subsequently levelled at the RHA by Washington NTDC (9.25).

On other criteria, Ryhope was considered superior because of the large site there (250 acres, compared to 60 acres at Washington) which was also already in NHS ownership. Staff recruitment was not seen as a problem in either case, though the employment consequences of reducing existing services at Ryhope were a possible cause for concern, since the NHS was one of the principal employers in that area. Summing up, the RHA felt that a convincing case had been made for a community hospital in Washington, but not for a general hospital. Ryhope was favoured because of land availability and ownership and because there already existed a labour force likely to include appropriately qualified staff, due to the tradition of employment in local hospitals (9.26).

As in the case of Peterlee, however, these proposals were by no means universally acceptable. On technical grounds, opposition was forthcoming from Tyne and Wear CC, who had
carried out - independently of the RHA's investigation - an assessment of alternative strategies for hospital location (reported in Riley, 1982). Since the RHA had not made explicit their patient referral policies, two options were explored. These were, firstly, allocation of patients to all general hospital beds in the AHA - including either Ryhope or Washington - and, secondly, allocation of patients to beds in Sunderland General Hospital and Washington or Ryhope. In neither situation was there a sizeable difference between the Washington and Ryhope locations (table 9.8). However, with the exploration of various options, such as capacity-constrained solutions with varying referral policies (either to the nearest hospital or to the nearest available bed), a location at Washington began to show clear advantages, of the order of 10% in aggregate terms (table 9.8). This was felt to be 'significant' in a land-use transport planning context, and indeed an official of Tyne Wear CC suggested that siting the hospital at Washington would save the Council some £5 million over 10 years. This would accrue from not having to repair and/or replace roads in the Ryhope area, and indeed in the Sunderland area more generally, as a result of Washington's superiority in terms of accessibility and traffic generation (9.27). Though there was little to choose between the sites in terms of space for car parking or access by public transport, the benefits of a hospital at Washington would, it was felt, be more widely dispersed throughout the western part of Sunderland AHA(9.28). Hence Tyne Wear CC favoured Washington on the grounds of what they saw as its superiority in locational terms. However, this report was rejected by the RHA on the grounds that its conclusions could be accounted for by the 'margin of error attached to such calculations' (9.29) - though the RHA preferred not to indicate
Table 9.8 Summary of location-allocation analysis carried out by Tyne-Wear Council on alternative hospital strategies.

<table>
<thead>
<tr>
<th>Analysis</th>
<th>Washington</th>
<th>Ryhope</th>
<th>Difference (R-W)</th>
<th>Per-cent Difference (R-W)/(R-W)</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RHA Policy</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(i) Allocation to all general hospital beds in the district including Washington or Ryhope.</td>
<td>7532520</td>
<td>7525355</td>
<td>-7185</td>
<td>-0.0%</td>
<td>Total travel (average time)</td>
</tr>
<tr>
<td>(ii) Allocation to general beds in Sunderland General and either Washington or Ryhope.</td>
<td>7698583</td>
<td>7688788</td>
<td>-9795</td>
<td>-0.0%</td>
<td>Total travel (average time)</td>
</tr>
<tr>
<td><strong>County Policy</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(i) Uncapacitated allocation to the nearest of all hospitals plus either Washington or Ryhope.</td>
<td>4345473</td>
<td>5029764</td>
<td>684291</td>
<td>+15.7%</td>
<td>Total travel (average time)</td>
</tr>
<tr>
<td>(ii) Uncapacitated allocation to the nearest hospital-either Sunderland General and either Washington and Ryhope.</td>
<td>5509096</td>
<td>6123727</td>
<td>614631</td>
<td>+11.1%</td>
<td>Total travel (average time)</td>
</tr>
<tr>
<td>(iii) Capacitated allocation to the nearest of all hospital beds plus either Washington or Ryhope.</td>
<td>4713318</td>
<td>5587338</td>
<td>874020</td>
<td>+18.5%</td>
<td>Total travel (average time)</td>
</tr>
<tr>
<td>(iv) Capacitated allocation to the nearest bed in Sunderland General and either Washington or Ryhope.</td>
<td>5764607</td>
<td>6469813</td>
<td>705206</td>
<td>12.2%</td>
<td>Total travel (average time)</td>
</tr>
</tbody>
</table>

Source:
Tyne and Wear County Council - Hospital Strategies for the Sunderland Area - report to the Management Committee, 16.2.81.

*Proportion of RHA policy time
the criteria (for instance referral policies) which they would have employed in such an analysis. Clearly, then, the RHA's preferred policy option was open to criticism on technical grounds. However, it is also evident that - on a political level - the strategy was still open to dispute. In this respect the Washington NTDC and the 'Hospital for Washington' campaign were particularly vociferous in their criticism and the subsequent debates are analysed more fully below (Chapter 10). Despite the RHA's detailed consideration of various options, then, their proposals were not considered acceptable on technical grounds - witness the arguments of Tyne Wear CC - nor did they satisfactorily resolve the dispute from the point of view of a variety of interested parties. The way in which the conflicting points of view on this topic were resolved, is examined below; the concluding section of this chapter discusses the common issues arising from the evidence presented herein.

9.5 Concluding remarks
This chapter has illustrated the use to which knowledge can be put in policy making, with reference to three disputes about hospital location. It should be emphasised, firstly, that the apparent inability of the procedures employed effectively to resolve the issues to which they were addressed (particularly in the Washington and Peterlee examples) is in no sense an indication of incompetence on the part of those carrying out the studies, nor is it attributable directly to the technical limitations of the procedures used. Rather, the evidence exemplifies the problems inherent in attempting to solve political disputes by technical methods, and demonstrates the difficulties inherent in certain approaches to public facility location. It also lends further weight to Offe's observations
concerning the logic of state policy formulation. These issues can perhaps best be exemplified by the case of hospital location in the Durham Health District, but they are also relevant to the other examples given here.

Considerable shortcomings existed in the work carried out on behalf of Durham AHA. While these could have been overcome (which would have been desirable on purely technical grounds), this would not have affected the outcome of the dispute. For, irrespective of the technical merits (or otherwise) of alternative pieces of research, such knowledge can be used in support of the intentions of conflicting parties to planning disputes. Although the two studies of hospital location in the Durham Health District both claimed to be objective analyses of the same issues in the same area, they came to different conclusions and were used in support of competing views. This can partly be explained by the use of different techniques of analysis, but of more importance is the fact that the divergent intentions and perceptions of the RHA and AHA were influential in defining the way the problem was to be analysed. Similar problems were evident in the case of Sunderland AHA; indeed, at one point the Northern RHA were accused of defending a committed position. Finally, the Newcastle study illustrates the use of an image of an 'ideal type' of hospital provision to promote the interests of certain parties. Three implications seem worthy of comment.

Firstly, such planning disputes ultimately cannot be resolved via application of the procedures discussed here. It is undoubtedly possible to evaluate alternative spatial arrangements of public facilities, thereby indicating in what direction resources should be channelled to achieve a particular objective. However this presumes the existence of a consensus on the goals
to be achieved and the means whereby they are to be attained; without such a consensus the kind of situation described above - in which parties to planning disputes produce knowledge to serve particular interests - may arise. However, such procedures may allow planning decisions or strategies to be justified by reference to allegedly 'scientific' or 'objective' allocation procedures.

This in turn begs the question of what criteria are considered when such decisions are taken. Location-allocation methods, for example, are far from value-free; they present a view of society which implicitly accepts existing social conditions and, by presuming the continued existence of such conditions, reasserts the existing social order as setting boundary conditions within which policy formulation must take place. Such arguments are not developed here (see Chapter 11; and also Lewis and Melville, 1978), but they can be linked to the evidence given above. For example, analysing a hospital planning issue in purely spatial terms seems to rule out discussion either of the appropriateness of the services provided or of such matters as the social needs of the population to be served. In seeking to resolve these disputes by reference to purely technical criteria, planning procedures limit the options to be discussed and, indeed, operate to the advantage of institutions that already exist.

Finally, if academic research can be employed to serve particular interests in planning disputes, those involved in such work should, at the very least, point out why such conflicts arise and consider the use to which their work is put. This chapter has argued that allegedly neutral methods could not, of themselves, resolve the issues to which they were applied. To
understand more fully the emergence and resolution of such problems, it is essential to consider public facility location in the context of theories of society and the state (Chapters 2, 3); this facilitates comprehension of the decision-making process. Chapter 10 therefore presents detailed discussions of the resolution of disputes on hospital location.
Footnotes

9.1 Various documents held in RHB 195F (Medical Planning of Hospital Services: Durham) confirm that a new site was actively being sought, but a satisfactory alternative was not found.

9.2 The height restriction had been imposed so that no building would be constructed in Durham City which would dominate the skyline to a greater extent than Durham Cathedral; documents and notes of meetings held in RHB 195F confirm this.

9.3 Drs. M. O'Brien and A. Sutherland.

9.4 Durham Health District, Policies for Development of Hospital Services (internal memorandum, Durham AHA, 6.7.79).

9.5 Ibid.

9.6 Notes of a meeting between RHA and AHA officials on Durham Health District Development Programme, 26.4.79 (unpublished paper, Durham AHA).

9.7 Population data were extracted from Census Research Unit files of 1971 Census data, held on the Northern Universities Multiple Access Computer (NUMAC).

9.8 Notes of a meeting between the Northern RHA and Durham AHA, 11.3.80.


9.10 Ibid.

9.11 Ibid.

9.12 Notes of a meeting between the Northern RHA and Durham AHA, 11.3.80.

9.13 Ibid.

9.14 Ibid.

9.15 Letter from the consultant lobby at NGH to the Minister of Health, 21.12.66 - held in RHB 195.

9.16 Memorandum by consultants at NGH to the RHB on the development of hospital services in the Newcastle area, July 1967 - held in RHB 195.

9.17 Notes of a meeting between the consultants at NGH and the RHB, 28.7.67 - held in RHB 195.
This view was expressed in a paper on 'A University Hospital Complex in Newcastle' (16.4.69) prepared in support of the views of the Combined Medical Advisory Committee of the Newcastle HMC and the BG - held in RHB 195.

Notes of a meeting between the RHB and the City of Newcastle Planning Committee 25.7.69 (emphases added) - held in RHB 195.

Reported in the *Newcastle Journal*, 38.7.69 - emphases added.

Letter from the DHSS to the RHB, 11.9.69, summarising representations made by Henry Miller to the DHSS - held in RHB 195.


Letter from Geoffrey Rhodes (MP for Newcastle East) to the *Newcastle Journal*, 20.9.69.

Brief for the Chairman of the RHB for the meeting with the Secretary of State, 16.9.69 - held in RHB 195.

Letter from R.G. Tilmouth (Managing Director, Washington NTDC) to the RHA, 11.2.81.

This paragraph has summarised the arguments contained in the RHA's consultation paper entitled *Long Term Hospital Strategy for the Sunderland area*, November 1980.

Personal communication from M. Riley, Tyne and Wear CC, 11.8.81.

Hospital strategy for the Sunderland area - report by officers of Tyne and Wear CC, submitted to the Council's Management Committee, 16.2.81.

NRHA/Sunderland AHA meeting, on *Hospital Strategy for the Sunderland area*, 9.6.81.
10. The politics of hospital planning: specific case studies.

10.1 Introduction

The previous chapter showed that the spatial planning of hospital facilities ultimately could not be reduced to, or resolved by, technical procedures. The focus here is therefore upon the resolution of such disputes. Section 10.2 considers the development of hospital services in Newcastle upon Tyne, paying particular attention to a dispute concerning whether or not to construct a new hospital at Freeman Road, in the north-east of the city. The debate between the Northern RHA and Durham AHA about hospital strategy for the Durham Health District is then discussed in section 10.3. Finally, the response by the Northern RHA and Sunderland AHA to the campaign for a hospital in Washington New Town is examined.

10.2 Medical politics and hospital planning in Newcastle upon Tyne.

The evidence is presented in three sections. Developments between the 1946 Hospital Survey and the 1962 Hospital Plan, and the emergence of proposals for a hospital at Freeman Road, are examined first (section 10.2.1) followed by a discussion of opposition to the latter proposals (section 10.2.2); the resolution of the ensuing debate is then considered (section 10.2.3) and finally the major themes evident in this dispute are summarised.

10.2.1 Postwar developments and the emergence of plans for the Freeman Road Hospital.

There existed 12 hospitals in Newcastle upon Tyne
before World War II (figure 10.1). Though the City Council had proposed expanding NGH from 879 to 1228 beds, no major changes in capacity took place in wartime (Ministry of Health, 1946 (volume 10), 36-38). The physical condition of the hospital stock was generally satisfactory, though some concern was expressed about parts of the RVI, as well as certain small specialist and/or isolation units (the Eye Hospital, the Ear, Nose and Throat Hospital, and the Smallpox Hospital) (Ministry of Health, 1946, 37, 40-41, 49). Primarily because of limited resources for capital development (see Chapter 5), virtually no progress was made with the proposals for a major regional Hospital Centre in Newcastle (Chapters 4 and 8). The possibility of having four general hospitals (the RVI, NGH, Walkergate and a new hospital on the site of the Sanderson Orthopaedic Hospital, Gosforth) was discussed, but not pursued; this seems to have resulted from a relaxation of Civil Defence regulations, which had restricted the maximum size of general hospitals to 800 beds (10.1).

The Hospital Plan's point of departure was the facilities available in 1960 (figure 10.2) and its reference to Newcastle as a medical capital clearly had important implications in terms of the provision of regional and sub-regional specialties. Several major developments were already in progress at NGH and, with the completion of several schemes designed to modernise Newcastle's hospital facilities (Ministry of Health, 1962, 18-19), seven hospitals would close by 1975 (figure 10.3). Further schemes would concentrate development at NGH, the RVI and Walkergate, permitting the closure of two additional hospitals.

In practice, however, there has been a major departure
Figure 10.1: Hospitals in Newcastle upon Tyne in 1943
Figure 10.2: Hospitals in Newcastle upon Tyne in 1960
Figure 10.3: Proposals of the Hospital Plan for hospital development in Newcastle

Figure 10.4: Alternative sites for hospital development in Newcastle
from the Plan's intentions, namely the development of a third DGH at Freeman Road (figure 10.4), rather than Walkergate. From mid-1962 it had become evident that there would be problems in developing the Walkergate site. The City Council required extensive space there for a secondary school, while the County Council regarded the areas as a 'form of green belt' and, as such, felt that any development would have to be capable of being absorbed without detriment to local amenities. Finally, the NCB had an interest in the site since they wished to extract coal from underneath it (10.2). Moreover, it was likely that complete rebuilding of the Walkergate Hospital would be necessary (10.3). The Freeman Road site - of some 52 acres - had been suggested by the City Planning Officer as an appropriate alternative (10.4) and it was accepted by the RHB and Ministry of Health (10.5). Its main advantage lay in its being a virgin site - by contrast, Walkergate would have presented serious redevelopment problems - and it was also in a good location vis-a-vis present and anticipated population distribution (10.6). However, considerable opposition mounted against such proposals and this is the subject of the next section.

10.2.2 The development of opposition to the Freeman Road scheme.

It would be over-simplistic to see this opposition as a consequence of objections to Freeman Road per se. Rather the opposition that emerged was directed at the proposition that three DGHs should be provided in Newcastle, and at the RHB's plans to locate certain regional specialties - in particular cardiothoracic medicine - at Freeman Road. Pressures were emerging for the development of cardiothoracic medicine (10.7),
but if it were to be located at NGH, comprehensive redevelop-
ment of that hospital would be required (10.8). The RHB
were also faced with the possibility of having to accommodate
additional facilities (in particular, some high technology
equipment and a medical physics unit) at relatively short
notice. Given the constraints on developing NGH they there-
fore proposed locating the cardiothoracic unit at Freeman Road
(10.9). This provoked strong opposition from a lobby of
medical staff at NGH, who claimed that a third general hospital
would increase the complexities of hospital provision in New-
castle. They therefore advocated two hospitals - the RVI and
NGH - of approximately 1500 beds each (10.10). This was
rejected by the RHB because of the delays involved and also
because of the extensive planning that had gone into the
Freeman Road scheme (10.11), though a proposal to develop only
two DGHs had a certain 'emotional appeal' (10.12). The RHB
felt, moreover, that developing two DGHs would require ex-
pansion of the RHB facility to 1800 beds, because of the RHB's
obligation to provide certain regional specialties. This
would be logistically impossible at NGH and, if attempted at
Freeman Road, would produce a disproportionately high-rise
development, and would entail abandoning the RHB's substantial
capital investment in NGH (10.13). Moreover, because re-
development of NGH depended on advance provision of new
facilities on a third site (to allow 'decanting' of some de-
partments from NGH), a two-hospital scheme including NGH was
not practicable without serious disruption of services; in this
the RHB were supported by the Ministry of Health (10.14). The
RHB's proposals, for three DGHs of approximately 1000 beds each,
generated further debate in mid-1967.

The consultant lobby at NGH insisted that to develop
three hospitals of approximately equal size would be wasteful, duplicative of services, and lead to considerable disruption. Locating the cardiothoracic unit at Freeman Road would create delays (for example, by increasing staff travelling time) and separate the work of that unit from that of other regional specialties. The latter, in particular, should be avoided in view of the inter-dependence of the regional specialties; although these were highly disparate branches of medicine, such units shared highly specialised ancillary staff. Closer integration of the regional specialties was seen as essential (10.15). To achieve this, an in situ redevelopment of NGH, to an ultimate capacity of around 2000 beds, was proposed, and it was claimed that this was feasible without building Freeman Road Hospital as a decanting unit (10.16). However, the RHB objected that this would take twice as long as their own proposals, incur additional costs (around £3.5 million at 1967 prices), and deprive the residents of east Newcastle of a locally-accessible DGH (10.17).

Subsequently, the consultant lobby stressed the importance of developing Newcastle as a leading medical centre, though this should not be over-emphasised since similar views were held by several parties with an interest in this dispute (Chapter 8.3). Contemporary medical opinion also lent support to the proposals for centralisation (see Chapters 6 and 9); it was argued that developments in medical practice:

'had so changed medical opinion that it was now generally agreed that in the larger centres there should be a concentration of all the essential services within a single hospital complex'.

(10.18)

This reinforces the point made above (Chapters 6 and 9) about changing medical practice, and emphasises further
the scale of provision being considered. The RHB saw the advantages for medical practice of such proposals, but felt that the delays that would result were unacceptable. The RHB claimed initially that a third DGH was essential to facilitate decanting of facilities from NGH (10.19). However, it subsequently became clear that achieving a balanced, co-ordinated development of Freeman Road and NGH would be difficult. Both hospitals were likely to have relatively small numbers of acute beds because of the RHB's obligation to accommodate a large number of geriatric and regional specialty beds. Duplication of services was also likely, Freeman Road would not provide an accident service, and several regional specialties would be separated (10.20). Taking these factors into account, and noting the recommendation of the Royal Commission on Medical Education (1969) that Newcastle's Medical School was to be doubled in size, the RHB proposed a 1500-bed hospital at Freeman Road. The RVI would contain around 1300 beds, but NGH would be reduced to 450 beds - of which 370 would be in geriatric medicine (10.21).

In parallel with these developments, a view emerged that a centralised medical complex might be feasible, either by increasing the size of the RVI, or by providing a new hospital on land adjacent to the RVI (figure 10.4). The RHB were unwilling to entertain this due to the problems they had encountered in obtaining the Freeman Road site (10.22). However, opinion within the BG swung towards a centralised development from early 1969 (10.23), on the grounds that, if Freeman Road was built, hospital services would be 'dismembered and scattered'. The result would be:

'a legacy of illogical hospital planning
... the present proposals (including Freeman Road) have no logical justification'.
(10.24)
Further support for such proposals was provided by Henry Miller, the Vice Chancellor of Newcastle University (see note 8.56), who claimed that the medical profession in Newcastle would prefer extensive delays in hospital development rather than the implementation of a 'disastrous' project, to which Newcastle University was:

'categorically opposed ... (Freeman Road) is out of date, uneconomic, and ... will militate against the efficient deployment of clinical resources'.
(10.25)

In Miller's opinion, the proposed Freeman Road scheme would merely be 'a truncated small general hospital' - he had previously described it as a potential backwater (10.26). A third DGH was unnecessary in any case, since Newcastle was not large enough to necessitate suburban hospital provision (10.27). Miller claimed that it would be possible to transfer the Freeman Road plans en bloc to the potential central site (10.28), and argued that centralised development would produce:

'(not) a single mammoth hospital complex, but interlinked hospitals virtually adjacent and furnishing an unsurpassed medical teaching potential'.
(10.29)

Finally, as discussed above (Chapter 8.4) the proposals for centralisation were also favoured by various prominent local politicians and the City Council. This can be understood in terms of the coincidence of interests of the medical lobby in promoting medical developments in Newcastle, with the interests of local politicians and planners in modernising Newcastle's environment. Indeed, the Council were prepared to seek parliamentary permission to release the required land; this would have been necessary since the land was owned by the Freemen of Newcastle (10.30).
However, the RHB were committed to proceeding with the Freeman Road scheme; it would be 'sheer lunacy' to revise their plans (10.31). The development of hospital facilities in Newcastle was said to be lagging behind the rest of the region; on a *per capita* basis, investment in the RHB's hospitals in Newcastle had been consistently below the regional average in the mid-1960s (10.32), and this situation would persist until and unless the new hospital was built (10.33). If further delays were necessary it was possible that alternative plans for capital development in the city might not reappear in the RHB's capital programme for at least five years, which would expose the RHB to the criticism that they:

'were trying to develop the hospital services of the region in a way which does not admit of logic'

(10.34)

Put another way, the problems of agreeing on a hospital strategy for Newcastle were such that developments in other HMCs were proceeding - relatively speaking - at a faster pace than in the city. This was evidently at variance with developing Newcastle as a 'medical capital' for the region. Finally, the RHB noted that it was important to provide a service for the population of the east end of Newcastle; on social grounds alone the RHB 'would have taken a great deal of shifting' from the Freeman Road scheme (10.35). However, the interests of the consultant lobby were clearly opposed to such a view; hence:

'the ideal solution could not be forthcoming simultaneously from the opposing points of view of the desirable development of medicine and of the necessary service to the public'.

(10.36)

This quote serves to emphasise further the severe
problems confronting attempts to 'optimise' public decisions and in this respect reinforces arguments developed above (Chapter 2).

On the one hand, therefore, the RHG's intention was to develop Freeman Road so as to avoid further delays and provide a new hospital for east Newcastle. Against this were ranged the City Council, the BG, the University, and a group of senior consultants, all of whom proposed a centralised development of the city's hospital services. So entrenched had the situation become that the apparent inability of politicians and planners to develop Newcastle's hospital services in a coordinated fashion - arising from their attempts to pursue different (arguably irreconcilable) goals - was perceived as having deleterious consequences in terms of improving access to health care:

'hospital development in Newcastle is a long way behind the rest of the region as a result of persistent disagreements between the experts and of the difficulty in getting agreement on the plan to be followed'
(10.37)

Evidently, therefore, an almost intractable dispute had arisen. This was resolved only after the intervention of Richard Crossman (10.35) in September 1969; the next section therefore discusses the way in which the decision was reached.

10.2.3 The resolution of the dispute: the decision to proceed with Freeman Road.

Crossman's intervention followed an interview with T. Dan Smith (Crossman, 1976, (volume III), 589) and representations from Henry Miller. Crossman called a meeting of all interested parties in Newcastle in September 1969. Since
no detailed record of that meeting is available, the following
draws largely on Crossman's (1976 (volume III), 656-659)
personal record of his role. Hence this account may seem some­
what one-sided in terms of the sources of evidence consulted.

Firstly, Crossman's remarks on the various alternative
proposals are of interest. Implicit in the various schemes
was the proposal that NGH would ultimately be run down,
irrespective of where the major development of Newcastle's
hospital facilities took place. Crossman noted that this had
had a serious effect on the morale of staff at NGH, and he
felt that:

'(this)seemed the most extraordinary solution... it seemed that if... (the) excellent buildings
at NGH were to go it was for the sake of building
a new hospital two and a half miles away, with
some of their own specialties'
(Crossman, 1976 (volume III), 657).

Crossman also emphasised the social benefits of build­
ing a hospital in east Newcastle, arguing that proposals for
a large-scale centralisation of services represented a 'case
of elephantiasis' (Crossman, 1976 (volume III), 589). In
seeking to resolve the dispute, he noted general agreement
on five points. Firstly, there was no question of developing
three general hospitals; in the long term at least, it was a
question of either two hospitals or one central medical complex.
Secondly, and due in part to the complexities of development
there, there would be no large-scale investment at NGH. Thirdly,
it was intended to produce a central nucleus of 2,000 beds.
The remaining beds in the city were to have a role in teaching -
all were to be part of a University hospital group - and
finally, any delays in excess of 18 months were to be avoided
(10.39). Discussion therefore focused on three issues. Firstly,
whether it would be best to abandon the Freeman Road site altogether, concentrating all the beds in two general hospitals on the central site; secondly, the amount of delay which would ensue from such an alteration of plans; and finally, the location of the cardiothoracic unit (10.40).

On the first and second of these points, it was agreed that serious delays were totally unacceptable. In attempting to resolve such disputes, Crossman argued that:

'a point may well be reached where reopening the search for the ideal solution merely distracts attention from what has become the best solution available' (10.41)

A centralised development of services, Crossman argued, might well represent the best possible solution, but it would involve considerable delays for two reasons. Since the Free-
men of the city owned the land required for this development, its acquisition would require a Private Member's Bill (Crossman, 1976 (volume III), 659). Secondly, a detailed geological investigation would be essential to determine the extent of mining subsidence, since this was thought likely to inhibit construction work on the site (10.42). The RHB's claim that seven years delay would be involved, created a 'great deal of incredulity' (Crossman, 1976 (volume III), 659). Hence, the matter was settled by an architect's report - commissioned by Crossman - to the effect that even if the plans for Freeman Road could be transferred en bloc to the central site, there would be a minimum delay of two years; if these plans had to be revised at all (due to the different physical characteristics of the two sites) a minimum delay of four years was likely (10.43). Since such a delay was felt to be excessive the Free-
man Road scheme was agreed upon.
There remained one last obstacle to be overcome in the shape of the opposition of certain influential consultants to the proposal to locate cardiothoracic surgery at Freeman Road. Crossman emphasises the importance of this issue:

"Richardson, the leading doctor (10.44) was himself a cardiothoracic surgeon and it was the putting of the cardiothoracic unit on the Freeman Road site which really made him blow his top. He said that this unit must be on the central site because it had to link up with all sorts of other expertise and could not be separated off and put into a district hospital site... it was clear that if he could move the cardiothoracic unit to the centre it would eliminate some of his ferocity."

(Crossman, 1976 (volume III) 658 - emphases added)

The opposition to locating cardiothoracic surgery at Freeman Road had stemmed from the perceived inefficiencies in medical practice which would result from separating off what was an important regional specialty; this was a major reason for the initial opposition to Freeman Road (see above, section 10.22). Crossman therefore suggested, in order to placate this opposition, that an attempt be made to accommodate the cardiothoracic unit in the central medical complex.

Thus, the Freeman Road decision was upheld only after a dispute over hospital strategy which was prolonged for several years and, after apparently reaching deadlock in mid-1969, was resolved via Ministerial intervention. Yet some evidence suggests that Crossman could scarcely have made any other decision. Commenting on his preparations for the meeting referred to above, Crossman claimed that the brief he had received:

"was just a series of arguments for the RHB's case. I had said I would come up as an impartial investigator... I had to say to my officials... "This brief must not be left about because if it seems that I have been briefed with the RHB line, all the suspicions about the Department will be confirmed."

(Crossman, 1976 (volume III), 657 - emphases added)
A later reference emphasises the point:

'my own people, who were committed to the RHB, were terrified by my proposal for an independent arbitrator' (Crossman, 1976 (volume III), 659- emphasis added)

The above would appear to justify the inference that the main consideration (as far as the DHSS was concerned) was to avoid the interruption to the capital building programme that would result if Freeman Road were not built, though it would be unwise to extrapolate from this to the effect that Crossman's mind was entirely made up prior to the meeting at Newcastle.

In the final analysis, therefore, the major criteria to be considered were the amount of delay that would ensue if hospital services in the city were to be centralised, and the consequent effect on the RHB's capital programme. Hence, despite the advantages claimed for the central site, the decision to develop at Freeman Road was upheld. In the final section, major themes specific to this dispute are now restated.

10.2.4 Concluding comments.

Two themes are examined briefly, namely, the role of the medical profession in this debate, and the competing aims and objectives of various agencies of the state.

Medical opinion was of considerable importance in this dispute, in terms of structuring views on and attitudes to the organisation and delivery of hospital care (cf. Chapter 9.3). Thus the consultant lobby based at NGH were able to put up influential opposition to the Freeman Road scheme; this arose not only because of their fears that NGH would be downgraded, but also because they claimed that an inefficient fragmentation of specialist facilities would result, which, in turn, would
be against the best interests of the development of medical practice in Newcastle. The importance of this group's arguments is perhaps most clearly revealed by the use of the location of the cardiothoracic unit as a 'lever' with which to buy off an important source of opposition to Freeman Road. However, it would be an exaggeration to claim that this was a class or professional interest; the group of consultants at NGH were certainly homogeneous in their own interests, but they cannot necessarily be shown to be representative of their profession. This situation is perhaps best seen as an interest group employing its position within the NHS - a relatively privileged position, given the class character of the organisation of the NHS - to exert influence to achieve specified goals.

In considering the competing goals of various agencies of the state, the first point to note is that all parties concerned were in agreement with proposals that Newcastle should be developed as the region's 'medical capital'. Where they differed, however, was on the means whereby this would be achieved, in terms of the intra-urban development of services. Thus the RHB favoured a dispersed pattern, against which a vociferous lobby argued that concentrating facilities in the city centre was both possible and desirable, irrespective of the delays involved. Ultimately, it was seen as essential to proceed with Freeman Road to avoid the disruption to the RHB's capital programme that would otherwise ensue, though an attempt was made to placate the consultant lobby by offering concessions on the location of the cardiothoracic unit. Offe's (1976) characterisation of the state's activities as a process of crisis avoidance seems apposite here (see also section 10.5).
Moreover, the state must be seen to plan its services in a rational fashion. A decision against Freeman Road would have both seriously disrupted the RHB's capital programme and left Newcastle lagging behind the rest of the region in terms of hospital development; this would have exposed the RHB to the charge that its proposals for service development were somewhat arbitrary and haphazard, perhaps generating a crisis in their perceived capacity for rational administration. Hence it seems that Crossman could hardly have made any other decision.

The more general theoretical issues arising from this evidence will receive more detailed consideration below. This chapter now discusses the resolution of a dispute between the Northern RHA and the Durham AHA, concerning hospital strategy for the Durham Health District. This raises important issues concerning the divergent intentions of two levels of the NHS administration.

10.3 Hospital planning for the Durham Health District

Chapter 8.3 examined why the eastern part of County Durham had posed problems for hospital planners, not only because it was located in between the catchments of hospitals in Sunderland, Durham and Hartlepool, but also because of the difficulties involved in planning for the growing population of Peterlee New Town. Chapter 9 illustrated that attempts to resolve this problem, on a purely technical level, had ultimately failed to produce an agreed strategy. Here, attention is directed to the arguments and counter-arguments put forward by the respective authorities - the Durham AHA and the Northern RHA - and to the way their competing claims were resolved (see figures
9.1 and 9.2).

The AHA had argued that hospital facilities should be available in the Easington District, for several reasons (see Chapter 9.2). Hospital development in the Peterlee/Easington area would be a corollary of the AHA's strategy since reorganisation, which had involved the expansion of community services in that area (10.45). The AHA therefore proposed that two acute facilities would be developed in the Durham Health District; at Dryburn (the scale of which would be restricted by constraints on expansion (10.46)) and in the Easington area, possibly at Peterlee (Durham AHA, 1979, 41). The research described in Chapter 9.2 had confirmed the AHA's view that this was the optimum strategy, though the AHA also proposed retaining a community hospital in Chester-le-Street (10.47). Though the AHA had never envisaged a totally independent hospital in the Easington area, they nevertheless wished to see a substantial hospital presence there. In this regard they appealed for support to the DHSS's changing attitude to the scale of DGH development, arguing that rigid definition of hospital services as either 'DGHs' or 'community hospitals' was unwise in the light of variable local circumstances. Hence greater flexibility was required; the AHA wished to see an ad hoc or 'hybrid' type of hospital provision (10.48). Their proposed development would therefore include acute and maternity facilities, as well as psychiatric services. The AHA's appeal to the DHSS's changing policy on hospital size is of particular interest.

This policy (DHSS, 1980a) advocated a smaller scale of hospital provision (with a maximum of 600 beds) and greater flexibility in planning; as such it would appear to support
the AHA's case. However, one of the policy options excluded from this document was the provision of hospitals in communities which did not already possess them, such as new towns - yet this might be regarded as an inescapable consequence of the change in policy. The comments of various health administrators suggest that the rhetoric of this policy document conceals a desire to restrain new NHS capital investment; it was therefore unlikely that the AHA would receive support for its plans (see Chapter 7.4).

Thus the Durham AHA's proposals were based upon a recognition of local need and upon a desire to serve its resident population adequately. By contrast, the Northern RHA did not regard the provision of a fully comprehensive hospital service as one of the principal tasks of an AHA. Cross-boundary flows of patients were acceptable, in the interests of regional strategy, and efficient management (10.49). The RHA proposed that the Easington area would continue to be served by hospitals in Sunderland, Hartlepool and Durham (Northern RHA, 1979, 36-37). Similar emphases were evident in the RHA/AHA discussions on hospital strategy in March 1980. While noting that the AHA's motivation was a desire to develop an adequate service for its resident population, the RHA argued that the AHA had given only limited consideration to the strategic implications of their proposals:

'perhaps not unnaturally the subject had been considered only in the context of the Durham area itself'

(10.50)

By contrast, the RHA felt (on the basis of their own research - see Chapter 9) that the access problems arising from the existing arrangement of services were not excessive. Moreover, a new facility in Peterlee could not be viable. Its
catchment population was unlikely to exceed 60,000 and so it might not be able to guarantee the volume of work required for recognition for staff training purposes by the Royal Colleges of medicine (10.51). Hence staffing problems would develop. Such a development would also involve providing hospital facilities for the Durham Health District from three hospitals (Dryburn (Durham), Peterlee and Hartlepool) instead of two (Hartlepool, Durham). This did not appear to be a cost-effective solution, and it logically contradicted the AHA's own identification of the vital importance of cost-effectiveness in planning. Finally, an acute general hospital at Peterlee (whatever its size) would necessitate a comprehensive re-evaluation of schemes already in progress for the development of hospital services in the Hartlepool health district (10.52).

In exploring alternative strategies, the RHA rejected the possibility of a single DGH, on the grounds of accessibility, restrictions on the expansion of Dryburn and the difficulty of obtaining an alternative site. The RHA favoured locating a community hospital at Peterlee, linked to and supported by the DGH at Hartlepool. This would reduce the bed complement of Hartlepool DGH in certain specialties (long-stay geriatric and psychogeriatric units) which could appropriately be located in a community hospital, but it would not provide acute services and so it would not threaten the viability of the Hartlepool hospital. Such an option would also reduce the bed complement of Dryburn to around 600 beds - the maximum which could be accommodated there (10.53).

The final discussions on this issue raised three issues worthy of closer investigation. One of these - the use made of the studies of the implications of the respective strategies - has been examined above (Chapter 9). The remaining issues
concern the extent to which the competing claims of the AHA and the RHA could be reconciled and the way the Northern RHA responded to local political pressure from within the Easington District.

On the first point, though there was apparently quite a deep-rooted conflict - broadly speaking, between interests of regional strategy and local need for and access to services - a consensus was reached with surprising speed. A Northern RHA document considered that there was 'a substantial measure of basic agreement... and acceptance of the regional strategy' (10.54). This agreement seems to have emerged following assurances from the Northern RHA that their approach to hospital provision for the Easington area would be flexible, and that - in particular - outpatient facilities would be available in the new hospital. Nor were the Durham AHA likely to object to the RHA's proposal to link the Peterlee facility to Hartlepool DGH, as long as they were convinced of the adequacy of the facilities provided for their resident population (10.55). It may be that the prime concern of the AHA was to establish at least some hospital provision in the Easington area, and that as long as some steps were made towards this goal the AHA were prepared to give way on such issues as the control or content of such a facility. The Northern RHA and Durham AHA agreed, then, on a strategy which seemed to balance the RHA's concern for effective management (since no new general hospital was to be built) and the AHA's wish to provide a locally-accessible hospital.

Further matters to be considered concerned the potential political ramifications of developments in the Durham Health District. In particular, the potential closure of Thorpe Maternity Hospital generated some concern. This facility was
actually administered by Sunderland AHA, but that Authority had indicated that they wished to relinquish responsibility for it. Since this would remove the only local maternity service from the Easington area, the Durham AHA had been prompted to seek some way of making such a service available - hence their wish to see maternity facilities provided in Peterlee (10.56). Since there was likely to be a considerable public outcry if the Thorpe Hospital closed, (10.57) the RHA agreed to provide alternative local maternity services before this closure took place (10.58).

More generally, there is evidence which suggests that the RHA were anxious to distance themselves from the negotiations on this issue. An internal memorandum written in July 1980, noted that given the imminent NHS reorganisation, some uncertainty could still arise over specific responsibilities for planning in this area. Hence:

'(the RHA) must allow the priority for the Easington (hospital) development to be determined (and to be seen to be determined) locally (this issue) could readily attract a good deal of political attention... it might be better if the RHA were seen to have done nothing to delay or frustrate this development' (10.59)

Put another way, had the RHA's involvement been seen publicly as having interfered with (or even taken precedence over) local policy formulation, the policies of both authorities could have been questioned. In the case of the RHA, this was because they could be seen to be involved in local planning disputes. By contrast the AHA could be seen as being unable to plan without interference from above. The authorities therefore reached a compromise solution which could be represented as being acceptable to all parties to the dispute.
To conclude, this section has considered the emergence and resolution of a dispute over hospital strategy for the Durham Health District. At one level this exemplifies the 'equity versus efficiency tradeoff' (a problem which, it is held by many writers, is exemplified by public facility location - see Chapter 2). Thus the AHA's emphasis upon local need for and access to services contrasts with the RHA's concern for issues of strategic management. At another level, however, it could be argued that the two authorities were attempting to reconcile what were (ultimately) incompatible objectives. The responsibility of the AHA to provide adequate services for its resident population was ultimately at variance with the RHA's overall strategy for the region. While, therefore, the RHA could not go so far as to permit a full-scale hospital development in the Easington area, they were in a position to offer a compromise solution whereby a community hospital was to be sited in Peterlee. The specific implications of this dispute will receive fuller consideration in the conclusion to this chapter. Prior to that, consideration is given to the resolution of another dispute over hospital provision occasioned by rapid population change; this concerns hospital planning in Sunderland AHA.

10.4 The 'Hospital for Washington' campaign and the response of the NRHA and Sunderland AHA.

The planning problems posed for the Newcastle RHB by the decision to develop Washington New Town were discussed above (Chapter 8.3). For several reasons, a hospital was not built in Washington, but two developments necessitated a re-examination of hospital strategy for the Sunderland area from
mid-1979. These were the emergence of local political pressure for a general hospital in Washington, and a policy change on hospital size (see Chapter 7.4).

The Sunderland AHA, who were formally responsible for providing health services for the Washington area, had proposed concentrating hospital development on Sunderland DGH, with a second general hospital at Ryhope (figure 10.5). In opposition to this strategy, however, the 'Hospital for Washington' campaign had started as a 'spontaneous movement' in early 1979; by July 1979, 22,000 people had signed a petition calling for the construction of a 500-bed general hospital in Washington (10.60). The campaigners appealed to various arguments in support of their case.

Firstly, Washington's population had been expanding rapidly (to just under 50,000 by 1979—table 10.1), and the birth rate (22/1000) was almost twice that for Sunderland CB (11.7/1000). The AHA's intention to locate its second maternity unit at Ryhope would be 'disastrous' for Washington's residents, particularly for mothers with young children, who—if required to attend clinics at Ryhope—would face serious problems combining that with meeting their children from school. Furthermore, psychiatric and mental illness services were relatively inaccessible; the 190 residents of Washington admitted to psychiatric hospitals in 1978 had had to travel to a variety of units some distance away (table 10.2). As well as overloading hospitals which were already under pressure, this was a considerable inconvenience to patients' relatives. Finally, the campaign emphasised that a hospital would facilitate industrial development. Washington was 'the only growth point for industry in the Northern region' and it was claimed that
Figure 10.5: Proposals for hospital development in Sunderland AHA
Table 10.1 Population growth in Washington New Town

<table>
<thead>
<tr>
<th>Year</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>1972</td>
<td>31,000</td>
</tr>
<tr>
<td>1973</td>
<td>32,690</td>
</tr>
<tr>
<td>1974</td>
<td>35,900</td>
</tr>
<tr>
<td>1975</td>
<td>37,900</td>
</tr>
<tr>
<td>1976</td>
<td>41,500</td>
</tr>
<tr>
<td>1977</td>
<td>46,565</td>
</tr>
<tr>
<td>1978</td>
<td>47,733</td>
</tr>
<tr>
<td>1979</td>
<td>49,619</td>
</tr>
<tr>
<td>1980</td>
<td>53,231</td>
</tr>
<tr>
<td>1981</td>
<td>55,915</td>
</tr>
</tbody>
</table>


Table 10.2 Psychiatric hospitals to which patients from Washington were admitted, 1978.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Number of admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Durham County</td>
<td>102</td>
</tr>
<tr>
<td>Winterton</td>
<td>75</td>
</tr>
<tr>
<td>St. Nicholas</td>
<td>5</td>
</tr>
<tr>
<td>Cherry Knowle</td>
<td>2</td>
</tr>
<tr>
<td>Darlington Memorial</td>
<td>1</td>
</tr>
<tr>
<td>South Shields General</td>
<td>1</td>
</tr>
<tr>
<td>Newcastle General</td>
<td>3</td>
</tr>
<tr>
<td>St. Luke's</td>
<td>1</td>
</tr>
</tbody>
</table>

Source: Letter from the 'Hospital for Washington' campaign to Dr. Gerald Vaughan, 1980 - held in Northern RHA Planning Division files.
industrialists were 'disconcerted' to find there was no hospital available, though whether this had influenced firms against locating there cannot be evaluated from the available evidence. It was also claimed that more time was lost to industry as a result of people travelling 'unnecessary' distances to hospital, than was lost through strikes (10.61).

Secondly, hospital strategy had to be reconsidered in the light of changing policy on hospital size, which sought to limit the maximum number of beds provided in DGHs (DHSS, 1980a). Hence the previous strategy for Sunderland AHA - developing Sunderland DGH to 944 beds, supported by a second general hospital - was no longer acceptable (10.62). For these reasons, hospital planning for Sunderland AHA was reconsidered. Two versions of the RHA's consultation paper on this matter are considered here; a draft version of this paper gives an interesting insight into their views.

This paper argued that acceptance of Ryhope as a site for the second general hospital in Sunderland AHA had not only resulted from NHS ownership of some 250 acres of land there (which would greatly expedite development), but had also been influenced by recollection of 'local political pressure' following the closure of Seaham Hall Hospital in late 1977 (10.63). This had provoked a considerable local reaction (10.64), and since the Ryhope Hospital was a major employer in an area of high unemployment, the RHA anticipated 'strenuous local political activity' if that hospital was to be run down (which would follow if Washington was chosen as the site for Sunderland AHA's second major hospital). The RHA were clearly unwilling to risk a repetition of events at Seaham Hall and it would seem that this was an important - though not necessarily
decisive - factor in favour of Ryhope. However, the final version of the RHA's strategy made no mention of this point, emphasising rather that Ryhope's advantages were the ownership of the site, its potential for development, and the ready availability of trained personnel (10.65). The RHA's strategic proposals are shown in figure 10.6; the response to these is now discussed.

Firstly, the Washington NTDC did not accept these proposals and claimed that the RHA were defending a predetermined conclusion (10.66). In their view, scant consideration had been given to the views of the local community, and in particular to the 'vigorous, comprehensive and non-political' case pursued by the 'Hospital for Washington' campaign. They claimed that the proposed strategy ignored the needs of the young and growing population of Washington, and was oriented more towards the convenience of administrators and staff than to the interests of patients and visitors. Moreover, the NTDC felt that the lack of a hospital in Washington could hinder the attraction of industry (10.67). However, the RHA felt that the attraction of industry was 'not relevant' (10.68) - a view which apparently ignored the NTDC's claim that there was substantial support for a hospital from industrialists in Washington (10.69). Supporting the NTDC, Tyne and Wear CC claimed that, in locational terms, Washington was superior to Ryhope (see Riley, 1982, and Chapter 9). Against this, Gateshead and South Tyneside AHAs were concerned at the potential threat to staff recruitment if a DGH were built in Washington. Moreover, such a development could threaten the viability of the Queen Elizabeth Hospital, in Gateshead, by reducing patient flow to that hospital. Finally, as Durham CHC
Figure 10.6: Northern RHA's proposed strategy for hospital development in Sunderland AHA.
observed, not developing the Ryhope site would further penalise those residents of the Easington District who used hospitals in Sunderland AHA, since they would then have to travel four miles further to receive treatment at hospitals in the centre of Sunderland (10.70).

Though the RHA's proposals had thus generated considerable dissatisfaction in certain quarters, the RHA were to insist that this strategy be carried through, although they reassured the campaigners that a community hospital would be provided in the western part of Sunderland AHA (10.71). It was logistically impracticable to provide the local facilities requested; in particular, it was unrealistic and uneconomic to provide a second accident and emergency unit in the AHA (10.72). The RHA also argued that the delay caused by this dispute was creating planning blight, because the progress of several other schemes (including the second stage of Sunderland DGH) depended on agreement being reached on hospital strategy for the AHA as a whole. In addition, the delays were lowering staff morale at the Ryhope Hospital and hindering the disposal of surplus NHS land at Cherry Knowle Hospital (a psychiatric facility adjacent to Ryhope Hospital - figure 10.5) (10.73). Hence the Ryhope site was preferred.

However, this strategy was reviewed in mid-1981, following an indication of a more flexible attitude to hospital size on the part of the DHSS. Previous guidance (DHSS, 1980a) had emphasised that new hospitals should be restricted to 600 beds, but this would not be imposed as a rigid size limit if 'cogent and persuasive arguments' could be adduced in support of any proposals to exceed this limit. This once again opened up the possibility of a major concentration of hospital development in the centre of Sunderland, particularly at
Sunderland DGH. If it proved essential to build a second major hospital, the preferred option was Ryhope, but the RHA did not wish to take a final decision without re-examining the potential for town centre development. Four strategies were considered (figure 10.7.1 - 4).

The RHA argued that developing Sunderland DGH to 1200 beds would be preferable since it offered the most accessible pattern of hospital services for the catchment as a whole (figure 10.7.1). This would certainly have reduced the disparities in access to services within the AHA which would have resulted from siting a second general hospital at a peripheral location (either Ryhope or Washington), but in terms of aggregate distance travelled, two facilities would have reduced the overall 'system cost'. The attraction of such a strategy may have been that it compromised between the Washington and Ryhope sites, rendering the two centres virtually equidistant from the DGH. However, safety considerations ruled out this option; Sunderland DGH could not be developed to more than three storeys, and therefore the requisite number of beds could not be accommodated there. A further option would have split hospital development between Sunderland DGH and the Havelock Hospital (see figure 10.7.2); the latter would have accommodated 370 beds with the DGH taking the balance. However, the large concentration of specialist diagnostic facilities at the DGH, and the size difference between the two hospitals, made it likely that Havelock would be little more than a 'satellite' hospital. Moreover, this option would involve providing 9 hospitals rather than 8, since Havelock was not to be retained under any other option (figure 10.7). In addition, since there would be
Figure 10.7.1, 10.7.2: Alternative strategies for hospital development in Sunderland AHA

Figure 10.7.3, 10.7.4: Alternative strategies for hospital development in Sunderland AHA.
financial benefits from selling the Havelock site if it was not to be developed, there seemed to be sound arguments for rejecting this option.

The RHA was therefore drawn back to the question of whether to develop a second general hospital at Washington or Ryhope. Arguing that no 'conclusive' arguments had been advanced which would favour Washington, the RHA reaffirmed their earlier strategy of developing Ryhope. It was felt that provision of accident and emergency facilities (which had been requested by those campaigning for a hospital in Washington) at more than one hospital was impracticable; Ryhope would be considerably easier to develop (due mainly to land availability); and though it was conceded that Washington might have been more accessible than Ryhope, such considerations 'could not be the key determinant' between alternative strategic options (10.74). At their meeting in November 1981, the RHA therefore resolved that the future strategy for hospital development in Sunderland AHA would be based on development of the existing general hospitals on the Sunderland General and Ryhope sites, complemented by community hospitals in Washington, Houghton-le-Spring and Sunderland itself.

To summarise, opposition to the proposal to develop Ryhope as a general hospital had originally stemmed from the residents of Washington, from Washington NTDC, and from Tyne and Wear CC. Their arguments highlighted the social needs of Washington, the need for locally-available medical services in order to facilitate the pursuit of Washington's role as an industrial growth point, and the accessibility implications of Ryhope and their attendant consequences for road provision. In the face of these demands, the RHA reviewed its strategy.
In purely spatial terms, and on several other criteria, the two locations were evenly balanced, but Ryhope was favoured on the grounds of land ownership and also because of the potential political ramifications consequent upon a run-down of employment there. The objections of Tyne and Wear CC (that in terms of aggregate travel statistics, Washington offered a superior location) were dismissed on the grounds that their results fell within the 'margin of error' attached to such calculations. Finally, the RHA had rejected as irrelevant the NTDC's claim that a hospital would facilitate the attraction of industry to Washington.

Thus the attempts of various agencies of the state, and a social group located outside the state apparatus (the Hospital Campaign) to pursue their own goals, gave rise to a variety of claims, not all of which could be satisfied given constraints on what the RHA could achieve. Though attempts were made to examine alternatives to Ryhope (for example, the possibilities for development in the centre of Sunderland were considered), considerable importance seems to have been attached to the likely political ramifications of any withdrawal of facilities from Ryhope. Coupled with the problems of developing other strategies, such considerations seem to have been of decisive importance in terms of leading to a decision to develop a general hospital at Ryhope.

10.5 Concluding comments

This section now draws together common themes from the foregoing. These concern the framework within which this evidence should be interpreted, the constraints on the state's ability to implement its declared intentions, and the nature
of the policy formulation process. It is also shown, finally, that decisions taken by the state may themselves be a source of disfunction.

Clearly, these issues cannot be explained solely in terms of the intentions, actions and statements of key individuals. Such an account would consider the constraints on the ability of agencies of the state to realise their goals. For example, at one level, institutional arrangements limit the scope for manoeuvre of certain agencies. While the City Council could justifiably voice its opinions on the Freeman Road dispute, it had no direct authority to influence the outcome, other than by virtue of its control of land use planning. Likewise, NTDCs had no formal responsibility for health service provision, nor were appropriate institutional arrangements set up to facilitate the planning of new town health services. However, at another level, various structural constraints on the activities of the state are of more decisive importance, and these are considered below.

Moreover, it is also worth reiterating the points made above (Chapter 3) concerning the limitations of pluralist, managerialist, instrumentalist and structuralist accounts of state practice. Pluralist views would be unable to account for why certain demands were conceded and others denied in the planning process - and, indeed, such an account would encounter difficulties in explaining why it was that specific demands were articulated by certain agencies or individuals in particular circumstances. Managerialist perspectives possess some merit in terms of directing attention to the actions of key decision-makers, but this would merely beg the questions of the criteria for identifying such individuals, and of why
they were able to exert influence in the first place. On the former point, it is rarely possible to specify who the key individuals are in cases such as those discussed here, in which much policy formulation is conducted by committees or sub-committees of the relevant authorities. On the second point, it could be argued that Richard Crossman was perhaps the most decisive individual decision-maker in the Newcastle study, but this would simply beg the question of why his intervention was called for in the first place.

If pluralist and managerialist views are therefore not sustainable, it must also be conceded that certain Marxist perspectives are over-simplistic. Thus, to view the state simply in instrumentalist terms would overlook the diversity of the claims made on behalf of a variety of interest groups and the fact that several concessions were made in all the disputes referred to. In no sense, then, did these decisions represent unequivocal 'victories' for any one group. Nor is it justifiable to interpret these decisions in structuralist terms - that is, as having been made in accordance with the requirements of 'reproduction' by a 'factor of cohesion' in society. Such an account would take little note of the limits to state intervention and of the constraints on the state's activities.

A more adequate understanding of state practice appears to be that provided by Offe (see Chapter 3). Via a combination of the contradictory demands placed upon it and the complexity of its internal organisation, the state is constrained in its ability to carry out its declared intentions. One consequence is that certain organised special interests may be able to make their claims heard and win substantial
concessions to their demands (Habermas, 1976a, 60). Thus the
privileged position available to members of the medical pro-
fession gave them considerable influence on the outcome of
decisions. This was clearly evident in the Newcastle case,
where a group of prominent consultants was able to delay the
development of the city's hospitals for some time. While the
RHB ultimately obtained agreement to its original proposals,
this was achieved only at the expense of concessions on the
location of the cardiothoracic unit in the future development
of Newcastle's hospitals. Similar influences were evident in
the Peterlee example, in terms of the emphasis on efficient
medical practice and the most appropriate scale of hospital
provision. These comments should not be seen as an attempt
to introduce - for instance - the 'autonomy of the medical
profession' as some kind of independent variable whereby these
disputes may be more satisfactorily explained. It is clear,
however, that in certain historical circumstances, certain
interest groups have been able to exercise a crucial role in
decision-making.

The state is further constrained by direct practical
pressures from those it serves. Hence, in the Newcastle case,
the RHB's concern to demonstrate that its planning was pro-
ceeding in a rational and coordinated manner. The decision to
locate a hospital at Ryhope was at least partly motivated by
a consideration of the political rep&rcussions of transferring
NHS facilities away from that site, and it could be argued that
seeking a centralised development of hospitals in Sunderland
offered an acceptable compromise between the Washington and
Ryhope locations. Finally, the RHA clearly intended to
minimise the apparent extent of their involvement in the Peterlee
case; witness the statement that priorities for hospital provision should be seen to be determined locally.

It follows from the constraints on the state that only a limited number of demands placed upon it can be satisfied. This in turn has implications for the character of discussions on the spatial planning of health services. These can be shown to be selective in character to the extent that they tend to ignore the social implications of alternative proposals. Such issues were raised only by agencies or individuals committed to campaigning for a more accessible pattern of service provision. Thus in Newcastle the emphasis was upon the most appropriate way of developing a major medical complex in the city; from this point of view, the precise spatial configuration of services was seen as irrelevant. While the RHB made some reference to service provision for the east end of Newcastle, their principal concern seems to have been the avoidance of disruption to their capital programme. Claims made on the basis of social need were more evident in the Peterlee and Washington cases, though in the former, the AHA came into direct conflict with the RHA over its strategic proposals, whereas in the latter, demands stemmed from local community organisations backed up by the NTDC. In both cases, however, the RHA were able to defuse potential problems, and this was attempted in two ways: either by attacking their claims on technical grounds (Chapter 9), or by emphasising considerations of strategic management and efficient planning at the expense of social needs.

It also appears that the policy formulation process takes the form of crisis management whereby the competing claims of a variety of interest groups may be defused - if never
entirely reconciled. Thus the decision reached in the Newcastle case not only satisfied the RHB, by avoiding a major interruption to their capital programme, but it also placated the demands of those advocating hospital development in central Newcastle. In the Washington and Peterlee cases, proposals were advanced for community hospital development in each town, while in the Peterlee case the RHA gave assurances as to the local availability of maternity services.

Furthermore, the policy formulation process cannot be likened to that of a private entrepreneur; the operational rationality of the state is fundamentally different, and is not easily specified. No explicit attempt has been made here to evaluate the policy formulation process in a normative sense - for example, by comparing this process and its outcome with what might have been produced as the result of a cost-benefit analysis of alternative proposals - but this process evidently bears little relation to such a framework, nor does it resemble the equity versus efficiency tradeoff, of which the problem of public facility location is often assumed to represent an example par excellence. A variety of criteria must be taken into account, arising from the necessity for the state to attempt to satisfy the competing claims on it; moreover, the state's ability to do this is clearly constrained.

Finally, the functions and decisions of the state may themselves be a source of dysfunction: the state cannot guarantee that its decisions will always produce results acceptable to all concerned without generating unintended consequences. Because decisions on the location of hospital services in the Sunderland and Durham health authorities were taken only recently, this point cannot be substantiated empirically with
reference to these issues. However, it is instructive to note developments following the decision to locate a hospital at Freeman Road. By the late 1970s, it had become clear that financing the new development was likely to precipitate reductions in services elsewhere in the city; indeed, this was seen as the only way to achieve the full commissioning of the hospital (10.75). In early 1977, the AHA drew up plans to save approximately £2 million from closures, and the AHA's Strategic Plan, published later that year foreshadowed the closure of certain peripheral hospital units to generate the revenue funds necessary to run the new development (Newcastle AHA, 1977, 10). A further - perhaps unintended - outcome of this decision has been the problem of managing acute hospital services split between three sites. A major policy review on this is currently in progress (see Chapter 7), and there remains resistance to Freeman Road among certain sectors of Newcastle's medical community. Consider the following:

'(Freeman Road) was one of the most terrible administrative blunders... one of the very bad planning mistakes... we are not prepared to dismantle our service in other hospitals to open Freeman Road'.

(10.76)

Thus the decision to build a hospital at Freeman Road has had certain unintended consequences, in terms of its effect upon other hospital services in Newcastle, and in terms of the necessity for subsequent policy reviews. This provides further evidence for the arguments of Chapter 3 concerning the state's capacity for rational administration, and also substantiates the arguments of Chapter 2, concerning the 'optimisation' of public decisions.
Footnotes

10.1 Notes of a meeting of the Special Committee for the Planning of the Newcastle Medical Centre, 25.11.57 - held in RHB 195.

10.2 RHB Capital Development Sub-Committee meeting, 2.11.62.

10.3 Noted in reports to the RHB by its Senior Administrative Medical Officer, 12.6.62 and 24.5.63 - held in RHB 195.

10.4 RHB Capital Development Sub-Committee meeting, 1.3.63.

10.5 Letter from the Ministry of Health to the RHB, 18.11.64 - held in RHB 195.

10.6 RHB Capital Development Sub-Committee meeting, 1.3.63.

10.7 Newcastle RHB: meeting of the project committee to consider the development of hospital services in Newcastle, 27.5.65 - held in RHB 195.

10.8 Ibid. See also a Site Appreciation of Newcastle General Hospital (n.d.) - held in RHB 195.

10.9 Senior Administrative Medical Officer's Report to the RHB Project Committee on the Newcastle Medical Centre, 27.9.65 - held in RHB 195.

10.10 A petition - signed by many prominent consultants at NGH and by academic staff of the Newcastle Medical School - was sent to the RHB and Ministry of Health.

10.11 RHB memorandum on the number of hospitals to be built in Newcastle, Sunderland and Middlesbrough (n.d. - probably late 1966).

10.12 RHB File Note of a conversation between the RHB Chairman and the Senior Administrative Medical Officer, 24.1.67 - held in RHB 195.

10.13 Report of the Senior Administrative Medical Officer to the RHB's Capital Development Sub-Committee, 3.2.67.

10.14 Letter from the Ministry of Health to Newcastle HMC, 7.3.67 - copy held in RHB 195.
Memorandum by consultants at NGH on the development of hospital services in the Newcastle HMC area (n.d.-July 1967?) - held in RHB 195.

Ibid.


Report of the meeting between the RHB and the consultants at NGH, 28.7.67 - held in RHB 195.

Ibid.

Memorandum on the development of hospital services in the Newcastle area, 1.5.68 - held in RHB 195.

Ibid.

RHB internal memorandum, 2.12.68 - held in RHB 195.

Meeting of the Combined Medical Advisory Committee of the Newcastle HMC and the BG, 14.1.69; see also minutes of the BG meeting, 1.5.69.

Group Medical Liaison Committee: Advice concerning the distribution of beds and specialties in future Newcastle hospitals, April 1969, held in RHB 195 - emphases added.

Letter from Henry Miller to the RHB Chairman, 13.5.69 - held in RHB 195.

Reported in the Newcastle Journal, 28.7.69.

This paragraph draws on representations made by Miller to the DHSS. The actual text of these was unavailable but a summary of his views was given in a letter from the DHSS to the RHB, 11.9.69 - held in RHB 195.

Notes of a meeting... regarding the possible development of a University Hospital Complex, 6.5.69 - held in RHB 195.

See note 10.27.
Notes of a meeting between the RHB and Newcastle City Council Planning Committee, 25.7.69 - held in RHB 195.

Newcastle RHB, Board Meeting, 6.6.69.

See figure 5.6, noting, however, that the data does not include the BG's Capital Accounts, which could not be traced.

Notes of a meeting between the RHB and Planning Committee of Newcastle City Council, 25.7.69 - held in RHB 195.

RHB document entitled 'Visit of the Secretary of State - brief for the Chairman of the Board', 16.9.69 - held in RHB 195 (emphasis added).

Ibid.

Ibid.


See note 8.51.

Newcastle RHB - File note on the meeting with the Secretary of State, 26.9.69 - held in RHB 195.

Letter from Crossman to the RHB, 22.10.69 - held in RHB 195 (this letter gave full details of Crossman's decision).

Ibid.

Ibid.


Various papers held in RHB 195 show that Dr. G.O. Richardson had been heavily involved in this dispute and had consistently opposed Freeman Road.

Notes of a meeting between representatives of the Northern RHA and Durham AHA, 11.3.80.

Due largely to building height restrictions (see Chapter 9).

Notes of a meeting between representatives of the Northern RHA and Durham AHA, 11.3.80.

Minutes of a meeting between representatives of the Northern RHA and Durham AHA, 11.3.80.


Minutes of a meeting between representatives of the Northern RHA and the Durham AHA, 11.3.80.

Northern RHA internal memorandum, 4.7.80 - square brackets in original; other brackets and emphases added by the author.

Letter from the 'Hospital for Washington' campaign to the Minister of Health, 1980. This is held in the Northern RHA Planning Division files, as are all papers referred to subsequently, with the exception of the press cuttings noted in footnotes 10.64, 10.75 and 10.76.

This paragraph has summarised the arguments of the 'Hospital for Washington' campaign (outlined fully in Ibid.).

Sunderland AHA, Review of Hospital Strategy: Report to the Regional Team of Officers, 8.7.80.


Reported regularly in the local press - see, for instance, the Newcastle Journal, 17.9.77, 7.10.77, 17.1.78, 24.1.78.

10.66 Letter from R. Tilmouth (Managing Director, Washington NTDC) to the RHA, 10.2.81.


10.68 NRHA notes of a meeting to discuss the location of a second general hospital within Sunderland AHA, 2.3.81.

10.69 Washington NTDC, Hospital Strategy for the Sunderland area - detailed response to the NRHA, 30.1.81.

10.70 NRHA - Hospital Services in Sunderland AHA: results of consultation, 17.3.81 - comments of Gateshead AHA, South Tyneside AHA, and Durham CHC.

10.71 NRHA notes of a meeting on Hospital Strategy for the Sunderland area, 20.3.81.

10.72 NRHA notes of a meeting with Sunderland AHA on Hospital Strategy for the Sunderland area, 9.6.81.

10.73 Ibid.

10.74 This account has drawn heavily on Northern RHA documents, in particular that on Sunderland Hospitals Strategy, 16.11.81.

10.75 Reported in the Newcastle Evening Chronicle, 3.3.77 - see also Chapter 7.3.

10.76 Professor I. Johnston - quoted in the Newcastle Evening Chronicle, 5.10.79 - emphasis added.
11. **Concluding comments**

In summarising the conclusions of this thesis, the four objectives stated in Chapter 1 are reiterated. These were:

- to evaluate geographical work on public facility location problems;
- to assess the utility of certain theoretical propositions on the state, with reference to their utility in accounting for the spatial outcomes of social processes;
- to provide a broad overview of major issues in the development of the acute hospital services of the Newcastle RHB (Northern RHA) area;
- to reconstruct in detail the decision-making processes whereby hospitals are located.

The extent to which these have been fulfilled is now assessed.

11.1 **The local planning issues.**

Viewed retrospectively, it is clear that a wholly satisfactory and comprehensive account of these issues would have been an unrealistic project, due to the complexity of the issues discussed, the number of agencies involved, and the protracted nature of the disputes. Any attempt at reconstruction can at best only be a summary, which is further constrained by such issues as survival of evidence. However, the following matters are of importance.

Firstly, it is clear that an investigation of spatial changes in service provision within this region cannot be conducted without reference to the economic, social and political
changes within it (Chapter 8). In particular, the development of Peterlee and Washington, and the proposals for modernising central Newcastle, both had important implications for discussions on hospital planning. The interaction of various agencies of the state is a key theme here. For example, the ability of NTDCs to guarantee the attainment of their population targets was a matter of some importance in discussing hospital provision for Washington and Peterlee. An understanding of the inter-relationships between population change, spatial policy and health service planning is essential if these planning problems are to be adequately understood.

Secondly, Chapter 9 demonstrated that these planning issues could not be resolved either by the application of the kind of spatial analytic methods reviewed in Chapter 2, or by appeals to what was taken to be an 'ideal type' of medical provision. Since the objectives to be achieved were open to discussion, so too were the means whereby alternative strategies were to be assessed. This touches on more fundamental points to be made later, and is therefore not discussed at this stage.

Thirdly, Chapter 10 summarised major themes in the negotiations on these three planning issues. Attention was directed particularly to the constraints under which planners were operating, to the claims of various parties and the extent to which these were granted, and to the factors which were decisive in these disputes. However, these were ultimately not explicable simply in terms of the actions and intentions of key agencies or individuals. By contrast, constraints on state intervention proved decisive and these are considered below (section 11.3).
11.2 Hospital planning 1948-1982 (Chapters 4-7).

A comprehensive chronology of all events in the study area was beyond the scope of this thesis. Discussion focused instead on specific themes selected in relation to theoretical propositions concerning the state. Where possible, these themes were related to particular planning issues. Thus Chapter 4 discussed the historical development of hospitals in Britain, considered the wartime negotiations on future hospital planning, and presented evidence about the problems to be solved by postwar planning. However, given severe restrictions on the availability of resources in the immediate postwar years, progress in hospital development was minimal (Chapter 5). The Hospital Plan's announcement in 1962 followed an important change in the character of state intervention in the British economy, namely the introduction of economic planning, but the specific form taken by the Plan was a result of a variety of technical developments in hospital planning.

However, the optimism evident at the time of the Plan's announcement has proved to be misplaced and exaggerated. The Plan's implementation has been subject to a variety of constraints (Chapters 6 and 7). Thus public expenditure policies have disrupted its timing, from the revision of the Plan announced in 1966 (Ministry of Health, 1966) to the ad hoc cuts imposed at various times in the 1970s. Partly in response, attempts have been made to rationalise the Plan; the Conservative government's (DHSS, 1980a) policy is the most recent in this respect. In addition, the scale of DGH provision has been reduced considerably from that envisaged by, for example, the Bonham-Carter Report (Central Health Services Council, 1969). Planning problems have also been posed both by rapid
localised population changes and by the social implications of service concentration. The problems of implementing the Plan have been exacerbated by recent public expenditure policies and this was exemplified by reference to developments in Newcastle AHA(T), where a combination of the effects of inflation and strictly enforced cash limits has necessitated proposals for dramatic reductions in services.

Chapters 4-7, then, have shown how broad changes in the British state in the postwar period in turn influenced events in the hospital service, and thus affected what could be achieved by local planners. In this sense these chapters serve as a context within which the material on local-scale planning should be interpreted. No attempt was made to provide a complete chronology of all events in the study area; rather, the evidence was employed selectively, to illustrate the constraints under which planning agencies operate. A more detailed examination of the Hospital Plan's implementation is clearly an important task. Furthermore, this research has concentrated totally upon spatial aspects of acute hospital provision. However, a comprehensive account of the hospital services of postwar Britain would have to consider the distribution of resources between sectors of the state hospital service, and also the balance between state and private hospital provision. These are important priorities for future work.

11.3 Theoretical implications: the role of the state

The arguments presented in Chapter 3 are now re-evaluated in the light of the evidence presented.

Firstly, it should be clear that this material cannot
adequately be understood in terms of managerialist or pluralist accounts of the state. Even if key 'managers' can be identified - and this was rarely possible in the disputes examined here - there is only limited value in discussing their actions without reference to the structurally-located constraints within which they operate. Likewise, the local planning disputes are characterised by a diversity of interest groups, and thus might be open to a pluralist interpretation. However, on closer examination it becomes clear that there are considerable differentials in the ability of these groups to guarantee the attainment of their objectives; certain interests and intentions consistently prevail. The limited consideration given, in the local case studies, to claims made on the basis of social need, exemplifies this. Interpretations which deny any connection between power and class - such as pluralist and managerialist views - give at best a partial understanding of state policy formulation.

The claims of several Marxist accounts of the state were also rejected as being over-simplistic. It is patently not the case that the state has acted as an instrument of the capitalist class. For instance, provision of state health services certainly benefits capital but it also represents an important concession to demands for social reform. More specifically, in the context of this work, it is not always clear that a direct link exists between capitalist class interests and the development of strategies for hospital provision. Structuralist accounts, such as those of Poulantzas, are functionalist in character and, as Giddens (1982) and Saunders (1979) observe, pose severe problems for empirical research since the concept of relative autonomy may be used
in an account of almost any conceivable historical situation. Finally, neither instrumentalist accounts explicitly consider the problem of the limits to state intervention.

In view of the limitations of such work, an assessment was made of the recent German debates on the state. Capital-logic views were rejected, for they tend to reduce events in capitalist society to being a result of the needs of capital. As Mößbey (1982, 28) points out, they therefore replace an economic determinism with economic functionalism. However, the views of Habermas and, in particular, Offe, provided a more convincing interpretation of the empirical material, on three counts.

Firstly, Offe provides important insights into the policy formulation process, demonstrating that its complexity arises neither from the incompetence of planners nor from the incompatibility of the subjective intentions of various agencies, but rather from the structural characteristics of the capitalist state and the changing character of the accumulation process. Policy formulation consequently follows a somewhat tortuous path, illuminated by what may be ill-specified criteria, and it can best be characterised as a form of crisis management. This is supported, for example, by the studies of local planning issues; the decisions reached could be characterised as strategies likely to minimise disturbances to the system. Many of the political solutions developed for hospital planning — from the 'Limit and Control of Expenditure' circular of 1950 (Chapter 5) to the ad hoc public expenditure reductions of the late 1970s — can be seen as short-term responses aimed at avoiding major system crises. Precisely because of the complex and crisis-prone nature of state policy-making, decisions
cannot be reduced simply to technical evaluations of alternative strategies, for there will be no guarantee that such solutions will be generally acceptable (see Chapter 9).

Secondly, Offe's concept of selection procedures, whereby the state (in general) seeks to secure capitalist interests while simultaneously excluding anti-capitalist interests, appears to have considerable validity in terms of elucidating the class character of the state. These procedures operate on four levels, namely structure, ideology, process, and repression. The latter was not directly relevant here but the others are considered in turn. However, such procedures do not operate mechanistically, nor are they necessarily as hierarchical as the above terminology might imply.

Structural selection procedures refer to the limits on those matters that can become the subject of state policy. One example is the evident resistance to full state control of the hospital service (Chapter 4). A rather better illustration, though perhaps beyond the scope of this thesis, is provided by the fact that the NHS was organised on a curative, rather than a preventive, basis. In this sense the NHS represented not so much a socialist transition in health service provision but rather a rationalisation of existing arrangements. However, it should be emphasised that the operation of this selection procedure varies historically, as illustrated by the current attempts to facilitate the expansion of private medical care.

Ideological procedures, operating within broad limits on the extent of state intervention, influence what the state actually does. A clear illustration would be the recent trends in hospital policy (Chapter 7) which can plausibly be linked to the currently-dominant 'new right' ideology. Likewise,
the ideology of modernisation evident in the Newcastle dispute (Chapter 8) was of some importance in terms of influencing the policy options put forward. However, Offe pays relatively little attention to the production of ideologies and the processes whereby they become accepted. In this sense his views require development, and the class-theoretic arguments of such writers as Gramsci (1971), with their emphasis on ideology and consciousness, may be important in this connection.

Offe also argues that the policy formulation process itself acts as a selection procedure on state policy. Navarro (1978) seems to deploy this procedure in a simplistic and, arguably, instrumentalist fashion; he proposes that social and spatial inequalities in the NHS are related to the class origins of the senior personnel of the service and of the membership of its planning committees. Such an interpretation - reminiscent of Miliband's (1969) views - can only be justified if it can be shown exactly how such groups are in a position to use their influence. The local planning issues exemplify this; in particular the Freeman Road dispute was precipitated, in large measure, by divisions within medical opinion regarding the spatial arrangement of services.

Finally, Offe stresses the historically-changing character of the capitalist state. Thus the extension of state control of health services, which involved providing services for use rather than exchange, posed serious problems for policy formulation. Subsequent developments have included various attempts to rationalise, reduce or restructure state expenditure in response to crises in the accumulation process. Thus the introduction of economic planning represented a response to the perceived limitations of Keynesian techniques
(Chapter 5). More recent public expenditure policies reflect a widely-held view of the unproductive nature of such expenditure. Perhaps the best single example of the consequences for hospital planning of the changing character of the British state is provided by a comparison of the 1962 Hospital Plan with the most recent policy guidance. The former document envisaged employing an expanding NHS capital building programme not only to equalise the distribution of NHS resources (on a per capita basis), but also to attempt to rationalise (or at least gain more effective control of) hospital running costs. By contrast the 1980 Consultation Paper, for all its rhetoric about a more spatially decentralised hospital service, seems concerned largely with restraining claims for new capital development.

Thus Offe's propositions about the capitalist state both facilitate an interpretation of the foregoing evidence and represent theoretical advances upon earlier Marxist views. Two points which perhaps require development concern his treatment of ideology and the question of the boundaries between the four levels of selection procedure discussed by Offe. Finally, a theme not developed in this thesis concerns the differential influence of sub-class interest groups on state policy. For instance, the medical profession cannot be seen as an undifferentiated entity; within it, there exist a number of groups with varying degrees of influence on NHS resource allocation. An examination of sectoral aspects of hospital planning would have clarified this matter; evidently it is necessary for theories of the state to confront sub-class divisions, though this is not to be interpreted as a justification for a rapprochement with pluralist views.
Finally, three possible avenues for future research on the state are identified. These concern the local state, the language in which state policies are expressed, and some unresolved epistemological problems.

Despite the superficially radical rhetoric of analyses of the local state (e.g. Cockburn, 1977; Saunders, 1979), no conclusive demonstration has yet been provided that this concept is anything other than a label denoting a local dimension of state action rather than an abstraction of social relations (Duncan and Goodwin, 1982). Debates have thus focused largely on consumption issues without considering production relations, though it is true that it may not be easy to link such apparently local issues with struggles between labour and capital (Cooke, 1982, 199). Yet the existence of this problem is no justification for separating off the analysis of consumption issues. Perhaps a crucial issue here is the extent to which national and local state formations are interlinked. Clearly the extent of autonomy allowed to the latter, and the tasks allocated to it, have varied over time and it is important to understand why and under what circumstances this variation takes place.

Secondly, a crucial theme in the empirical sections of this thesis (Chapters 4-10) concerns the language in which public debate on state policy formulation is conducted. Control over what issues are, or are not, addressed by public policy is crucial, and it is clear that not all interested parties necessarily have an equal opportunity to voice their demands. Kemp (1980) demonstrates this for the Windscale Inquiry and it is exemplified here by the local case studies. Moreover, the images presented in planning debates are of some importance.
in terms of gaining acceptance for particular views; Carney and Hudson (1974) illustrate this in relation to spatial policy within North East England, while Chapters 8 and 10 reveal the influence of certain groups within the medical profession in terms of putting forward certain views on the most effective organisation of health care delivery. Furthermore, control of information pertaining to planning matters (Roweis, 1981, 168) may be a key element in the selectivity of the state (Offe, 1974), since potentially unacceptable policy options may be excluded from debate. Hence the actual minutes of the meetings of planning agencies often contained only a partial account of important issues, and so reliance on background papers was essential. These remarks are not intended as an ex post rationalisation of the manner in which this work was conducted. Rather, they serve to emphasise the point that without a detailed reconstruction of the decision-making process, one is limited to inferring decision-making from its outcome. In summary, therefore, the links between state policy formulation, the interest groups involved in it, and the language in which public debates are conducted and policies put forward, all require much more detailed investigation.

The final issue pertaining to the state concerns two epistemological problems raised by Giddens (1982) and Harris (1980). These will not be resolved here but their status can perhaps be clarified. Harris (1980) objects to what he sees as the teleological character of historical accounts of the welfare state, whereby all events are simply attributed to the 'balance of class forces'. But the point is surely that this balance is essentially a contingent matter; it is incumbent upon the researcher to demonstrate how it was that particular
policies came to be adopted in specific circumstances. Giddens' (1982) distaste for the functionalist character of some Marxist approaches is easy to sympathise with, but this problem would be difficult to overcome if taken to its logical conclusion. For this would beg the question 'what would happen if the state did not act the way it does?' - a question which would be (almost) unanswerable empirically.

11.4 Implications for geography and public facility location.

It was argued above (Chapter 2) that much previous work on this topic had either considered only a limited range of issues relevant to its object of study, or had suffered from several technical and theoretical problems. In seeking a reconstruction of facility location theory as a theory of society, Dear's (1978a, 1979) views were endorsed in general terms but certain specific proposals were disputed. Here the arguments of Chapter 2 are reconsidered.

There seems to be only limited scope for constructing a location theory for public facilities along the same lines as that developed for the private sector. The complexity of public decisions is a matter of commonplace observation; in turn this can be related to the nature of the capitalist state (Chapter 3) and the empirical material (Chapters 4-10) supports such a view. Moreover, it has been shown that there are limits to the extent to which political problems may be resolved by, or reduced to, technical procedures (Chapter 9). If this is accepted, it follows that the approaches reviewed and evaluated above can be defended only on instrumentalist grounds (Batty, 1979).
Furthermore, it is felt that the fragmentation evident in research on public facility location can be overcome. By interpreting location decisions in their wider social context, it is possible to link the distributive outcomes of public decisions back to the structure of the social formation under consideration. This does not simply involve linking social policy to its social and spatial outcomes (Kirby and Jones, 1982); such an approach takes for granted the determinants of social policy. Technical problems remain in assessing the distributive impacts of public facilities, but it is surely of more fundamental importance to develop an adequate framework within which decision-making may be interpreted.

In this regard, Dear's views were endorsed as a point of departure for a public facility location theory, but certain refinements were proposed and the foregoing has sought to demonstrate their relevance. Thus an account has been given of hospital planning in the study area which seeks to avoid the pitfalls of structuralism (simplistically reading off public service provision from the 'material base' of society) and voluntarism (pitching explanatory accounts solely in terms of the intentions of individuals or agencies). This is perhaps best exemplified by the local case studies. These could have been discussed in terms of the subjective intentions of key decision-makers, but this would have ignored the constraints under which planners operate. In the Newcastle case for instance, constraints existed both on land availability and on the programming of the RHB's capital schemes. These proved decisive in the final analysis, but not before a powerful lobby of consultants and politicians had exerted sufficient pressure to
require persistent negotiations and evaluations of alternative sites. To say, therefore, that this decision was the result either of the constraints referred to, or of the intervention of the Secretary of State at the DHSS (and both would be valid on one level), would ignore this complex interplay of agents and structures.

Moreover, it is important to present a class analysis of these planning disputes and of the NHS as a whole. It is patently not the case that all classes or interest groups have an equal opportunity to press their claims and pluralist or managerialist views were rejected on this basis. More convincing analyses can be presented via an understanding of theories of the capitalist state (section 11.3, above).

Finally, the materialist perspective developed here permits the explanation of spatial changes in hospital provision in terms of the changing character of the state since 1945. Attempts have been made to demonstrate how certain solutions to planning problems came to be adopted in specific historical circumstances; these have then been linked to developments in the hospital service. Such an approach is more fruitful in accounting for spatial patterns of public facilities than the methods reviewed above (Chapter 2), which typically abstract facility location from its wider social context and thus reveal little - if anything - about why public facilities exist and hence about spatial patterns of these facilities.

To summarise, the foregoing has argued that Dear's (1978a, 1979) proposals provided a basis for a reformulation of facility location theory, but some refinements were deemed necessary. These arguments were substantiated via an empirical
investigation of state policies and hospital planning which stressed the importance of theorising the role of the state and the class character of state policy formulation. The approach adopted was claimed to be progressive insofar as it avoided the pitfalls of approaches identified within a tradition of regional science and, at the same time, sought to elucidate the relationships between society, social change and state policy formulation in relation to the hospital services of North-East England. To the extent that these have been linked together, the aims of the thesis may be said to have been realised. Thus an account has been given of hospital planning (Chapters 4-10) which (with some reservations) has been interpreted in the context of certain theoretical propositions about the state (Chapter 3). These propositions in turn follow from the reformulation of facility location theory advanced in Chapter 2.

One final implication of this research follows from the critiques of both certain forms of knowledge in human geography (Chapter 2) and approaches to theorising the state (Chapter 3), and also from the empirical evidence on state policy formulation (Chapters 4-10); at issue here is the use to which knowledge can be put. In attempting to elucidate the class character of the state and to demonstrate the limited and ideological character of certain approaches to geographical problems, this research shares certain common features with the 'critical theory' of the Frankfurt School (Horkheimer, 1972; Habermas, 1972; 1974; 1976a). Broadly speaking this implies producing knowledge constituted by an emancipatory cognitive interest - that is, an interest in transcending existing social relationships to achieve a society characterised
by communication free from domination. Within human geography, critical theory has been deployed by Gregory (1980) and Lewis and Melville (1978) to illustrate the ideological character of systems theory and regional science respectively. It is argued that, by adopting a particular form of explanation - 'traditional theory' (Horkheimer, 1972) - regional science produces accounts of social phenomena which conceal the possibility of social change but allow for partial modification of social processes. Both these arise because a symmetry between explanation and prediction is central to traditional theory; hence control of social processes is possible because the meaning of a prediction is in its technical application. Since successful explanations can only be produced if it is assumed that existing social relationships continue to exist, it follows that the use of such explanations in social engineering will have the practical effect of reproducing the existing social order. Moreover, these practical consequences are not dependent on the subjective intentions of individual social scientists (Habermas, 1972). The foregoing has only summarised briefly the elements of Lewis and Melville's critique (see Fay, 1975; Bernstein, 1976; Gregory, 1978) but it should be evident that this critique offers further grounds for rejecting the approaches discussed above (Chapter 2). As applied to public facility location, this would allow a demonstration that not only is the production of a facility location theory within the epistemological confines of regional science a technically difficult and theoretically problematic task, but it also implies adopting a covert political stance. Though apparently offering neutral techniques for planning, such an epistemology
offers a technology whereby piecemeal social engineering may take place, and provides little more than a means of reducing political problems to technical issues.

Such an argument undeniably provides an incisive critique of certain approaches within human geography, but there remains the problem of demonstrating that analyses of the class character of the state which - implicitly - seek to reconstruct social science as critical theory (e.g. Hudson, 1981; Krieger, 1979) necessarily follow from such a critique. Furthermore, the extent to which critical theory can be advocated as a model for social theory is still open to question (see Giddens, 1979). But it does seem that the metatheoretical critique offered by critical theory facilitates an understanding of the respective social functions of traditional and critical theory, though whether those working within traditional theory would accept such an analysis remains to be seen. However, this can only become a possibility if the ideological character of certain forms of knowledge and the class nature of existing social relationships can be demonstrated by the kind of analysis of which this work represents a preliminary formulation.
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Note: The abbreviations of titles of journals in this bibliography conform to those given in British Standards Institution (1975), The Abbreviation of Titles of Periodicals.


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Appendix 1: NHS organisation

This appendix briefly sets out details of (a) the organisation of the NHS and of the Newcastle RHB from 1948-1974 and (b) the post-1974 reorganised NHS. Since the subsequent (1982) reorganisation is not relevant to the foregoing evidence, it is not considered here.


The structure of the NHS, as it affected the hospital services in this period, is set out in figure A.1 (overleaf). Three points should be noted. First, for reasons discussed, inter alia, in Eckstein (1959), Navarro (1978), Foot (1973) and Crossman (1972), the Teaching Hospitals were organised under separate Boards of Governors who were responsible direct to the Minister of Health. Hence responsibility for the planning of Newcastle's hospital services was split between the Board of Governors and the RHB, and this clearly posed some problems of coordination (see Chapters 8-10). However, the Board of Governors merged with the Newcastle HMC from 1971, to create the Newcastle University HMC. The second point is that psychiatric hospitals were administered under separate HMCs prior to 1974. This posed certain problems with respect to the financial statistics employed in Chapters 5 and 6 (see appendix 2). Thirdly, in view of its remoteness from the rest of the RHB, a committee was set up to carry out the RHB's duties in Cumberland and in the part of Westmorland which fell within the Newcastle RHB. This was known as the Special Area Committee. However, its activities were not examined in detail above. A fuller account of the activities of the Newcastle RHB would clearly have to consider the reasons why this Committee was set up, its activities, and its relationship to the RHB. Such
Minister of Health

Regional Hospital Boards

Hospital Management Committees

Non-teaching hospitals

Boards of Governors

Teaching hospitals

Source: adapted from Eckstein (1959, 177)

Figure A.1: Organisation of hospital services in the pre-1974 NHS
a task was outside the terms of reference of this thesis. The functions of the various authorities are now described.

According to RHB(47)1, the 1946 NHS Act envisaged strong regional control of the service:

's the Minister of Health will discharge most of his statutory duty through RHBs... RHBs will act as the Minister's agents... on whom he wishes to confer the largest possible measure of discretion ...(but) the Minister wants the Board to feel ... a lively sense of independent responsibility'.

(RHB(47)1 - emphases added).

However, no formal schemes or regional plans were necessarily required, though Boards were expected to agree with the Minister on the general lines of future developments. Below the RHB level, HMCs were to perform the actual day-to-day running of the services, 'reserving power to RHBs to decide questions of wider policy' (RHB(47)1).

These functions were clarified by RHB (48)2. Three of the six functions prescribed for RHBs should be noted; these were:

'(a) the general organisation and supervision of the hospital and specialist services
(b) provision of the necessary premises...
for the provision of services for patients from the Board's area... (and)
(d) authorisation of all building, civil engineering and maintenance work by HMCs costing over £1,000'.

(RHB(48)2).

RHBs were to be responsible for:

'the strategy of the services in their area, for reviewing and assessing the resources of the service, planning the best use of them... and giving general oversight to the operation of the HMCs...'

(RHB(48)2).

Given that RHBs had to authorise any building work costing over £1,000 and since RHBs were responsible for strategic planning, the HMC's role was limited; indeed HMCs were simply
responsible for securing:

'the efficient management and administration
(of the hospitals under their control) within
the limits of ...(their) approved budget...
subject to any guidance given by the Board or
by the Minister, each HMC will be able to organise
the day-to-day operation of its services as it
thinks fit'.

(RHB(48)2 - emphases added).

Boards of Governors, in general, had similar responsibili-
ties to RHBs; as might be inferred from their separation from
the rest of the NHS, their particular responsibility was to
facilitate the development of medical education.

In the Newcastle RHB area, non-psychiatric hospital
services were administered by the HMCs shown in figure 5.1;
developments in the psychiatric services were not considered.
Two changes were made to the non-psychiatric HMCs; the first
of these - the merger (in 1971) of the Newcastle HMC and the
Board of Governors of the Teaching Hospitals - has already
been noted. The second was the reorganisation (in 1958) of
the Sedgefield HMC and Teesside and Cleveland HMC into HMCs
for North and South Teesside respectively. This in turn was
linked to proposals for major hospital development on Teesside
(see Chapter 5).

(b) The reorganised NHS, 1974-1982.

The intention of the 1974 reorganisation of the NHS was
to achieve closer integration of services provided by hospitals,
local health authorities and GPs. To do this it set up Area
Health Authorities at the sub-regional level. These were,
generally speaking, coterminous with local authority areas to
facilitate integration of the health and personal social
services. AHAs were responsible:
'for achieving national health care objectives through the provision of comprehensive health services designed to meet the needs of the communities within its districts... and for planning and developing services in consultation with its matching local authority and with the regional health authority'.

(House of Commons, 1972 - emphases added).

Below the AHA level, the day-to-day running of the service was based on health districts. These were not necessarily coterminous with local government districts, since the health district's boundaries would be related to health care needs. Many AHAs were responsible for only one or two health districts whereas others had up to five. Thus the Newcastle AHA(T) (see Chapter 7) was a single district health authority, whereas Durham AHA was responsible for four health districts. The boundaries between health authorities were in no sense regarded as barriers to the use of health services; cross-boundary flows would be appropriate according to the dictates of availability of services and patient choice and convenience. However, some conflicts have developed regarding the necessity for such flows and, more generally, over the nature and extent of services to be provided by an AHA in pursuit of its objectives (see Chapter 9).

Above the AHA, Regional Health Authorities (RHAs) were essentially charged with strategic planning. The RHA was to:

'develop strategic plans and priorities based on a review of the needs identified by AHAs and on the judgement of the right balance between the individual areas' claims on resources... (and to) review the plans of each of its areas to satisfy itself that they contain programmes to achieve necessary improvements in services, that they are attainable within available regional resources, that they are consistent with national and regional policies, and that they have been coordinated with the plans and activities of local authorities'.

(House of Commons, 1972)
RHAs are responsible for all major capital investment projects, and hence the planning of the future pattern of services in, for example, Sunderland AHA, was carried out largely at RHA level (see Chapters 9 and 10).
Appendix 2: Sources of evidence

Though the documents which were cited in the text have been referenced individually in footnotes, the sources from which these were obtained are summarised here for reference. Published reports and accounts have been referenced in the bibliography; this appendix notes those sources not readily accessible, and is divided into four sections, concerned with

(1) state papers and Public Record Office material;
(2) minutes and papers of health authorities within the area studied;
(3) miscellaneous sources;
(4) sources of information on hospital location.

1. State papers and Public Record Office material

Public Record Office (PRO) material is arranged according to the ministry to which it refers. Papers are then grouped in files on broad topics; within these, individual pieces contain material on specific issues. Thus MH 80/34 refers to piece 34 of Ministry of Health file 80. Cabinet papers are arranged in two series; CAB 128, minutes of Cabinet meetings, and CAB 129, memoranda prepared for the Cabinet. In addition to the Cabinet papers for 1945-1951, the principal sources were the following:

<table>
<thead>
<tr>
<th>File</th>
<th>Piece</th>
<th>Subject</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH 77</td>
<td>18</td>
<td>Survey of hospital facilities.</td>
</tr>
<tr>
<td>MH 77</td>
<td>25-27</td>
<td>Hospital and medical services.</td>
</tr>
<tr>
<td>MH 80</td>
<td>24</td>
<td>National Health Service: preliminary papers, 1939-1942.</td>
</tr>
<tr>
<td>MH 80</td>
<td>25-30</td>
<td>National Health Service:Secretary's bill papers, 1943-1946.</td>
</tr>
<tr>
<td>MH 80</td>
<td>34</td>
<td>Hospital services.</td>
</tr>
<tr>
<td>MH 88</td>
<td>49</td>
<td>Newcastle RHB: hospital land, buildings and development.</td>
</tr>
<tr>
<td>MH 90</td>
<td>54</td>
<td>Meetings of RHB Chairmen.</td>
</tr>
</tbody>
</table>

In addition, various references to parliamentary debates reported in Hansard are given in individual footnotes, as are references to circulars issued by the Ministry of
Health/DHSS.

2. Papers relating to activities of Health Authorities within the Newcastle RHB/Northern RHA.

2.1 Papers of the Newcastle RHB

Data on the location of hospitals are described below. Financial statistics were obtained from the RHB's Annual Accounts. These gave totals of capital expenditure in each hospital for each year from 1949-1950 to 1973-1974, with the exception of 1972-1973, for which the accounts could not be traced. This information allowed analysis of the intra-regional distribution of investment in non-psychiatric hospitals (figures 5.6 a-d). Capital expenditure in the RHB was also disaggregated by the use to which it was put (e.g. new construction etc.), but the accounts did not consider separately psychiatric and non-psychiatric hospitals. Hence discussion of the use of capital by Newcastle RHB (Chapters 5, 6) refers to capital expenditure for all hospital services in the region. The RHB's Annual Reports were also used but these appear to have been discontinued after 1957.

Evidence was also drawn from the minutes of the RHB's Planning Committee (1948-1962) and Capital Development Sub-Committee (1961-1974). According to the Newcastle RHB's First Report (1950, 20), the Planning Committee was intended to:

'organise and keep under review the hospital and specialist service, formulate extensions and developments thereof, and consider recommendations from its various sub-committees'.

The Capital Development Sub-Committee was responsible for administering the expanding capital building programme
<table>
<thead>
<tr>
<th>RHB File Number</th>
<th>Subject</th>
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<tbody>
<tr>
<td>195E</td>
<td>Medical planning of hospital services - Sunderland (2 vols.).</td>
</tr>
<tr>
<td>195F</td>
<td>Medical planning of hospital services - Durham (3 vols.).</td>
</tr>
</tbody>
</table>

It is important to note that various files and/or important individual papers either have not survived, or they could not be traced. Thus files RHB 145/F/1 (meetings between the RHB and the Ministry of Health) and 145/2/G (Survey of Long Term Development in the Region) could not be found. Individual volumes of certain files were also not traced, a case in point being volume 1 of RHB 194 (Hospital Services on Teesside). Finally, the RHB's submission to the 1962 Hospital Plan was not found.

2.2 Papers of the Board of Governors of the United Newcastle upon Tyne teaching hospitals.

Under the administrative arrangements set up at the establishment of the NHS, teaching hospitals were run by Boards of Governors responsible direct to the Ministry of Health (see Appendix 1). In the context of this research, this meant that the RHB and the BG were responsible for hospital services in Newcastle (until 1971, when the BG and its hospitals merged with the Newcastle HMC). Two particular problems arose. Firstly, the financial statistics employed in Chapters 5 and 6 are incomplete, as it proved impossible to locate the BG's capital accounts. Secondly, it was necessary to corroborate the evidence held in RHB files on hospital development in Newcastle (see Chapters 8-10); the Minutes of the Board of Governors (1948-1971) were therefore checked for this purpose.
from the late 1950s onwards. However the first volume of its minutes, which included the period up to May 1961 (when the RHB made its submission to the Hospital Plan) could not be found.

The following files covering specific issues of relevance to this work were also examined:

<table>
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<tr>
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<th>Subject</th>
</tr>
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<tbody>
<tr>
<td>43</td>
<td>Meetings of RHB Chairmen at the Ministry of Health.</td>
</tr>
<tr>
<td>47</td>
<td>Correspondence with Aycliffe NTDC (2 vols.).</td>
</tr>
<tr>
<td>47/A</td>
<td>Correspondence with Peterlee NTDC (2 vols.).</td>
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<td>47/B</td>
<td>Correspondence with Washington NTDC (2 vols.).</td>
</tr>
<tr>
<td>55/A</td>
<td>Hospital accommodation.</td>
</tr>
<tr>
<td>58</td>
<td>Transfer of hospitals to the Minister of Health.</td>
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<tr>
<td>58/A</td>
<td>Unoccupied hospitals.</td>
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<tr>
<td>58/C</td>
<td>Closures and change of use of hospitals.</td>
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<tr>
<td>58/D</td>
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<tr>
<td>58/E</td>
<td>Age distribution of hospitals</td>
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<tr>
<td>64</td>
<td>Age of hospitals.</td>
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<tr>
<td>65/17</td>
<td>Geriatric accommodation.</td>
</tr>
<tr>
<td>144</td>
<td>Planning of District General Hospitals (3 vols.).</td>
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<tr>
<td>145/D</td>
<td>Major capital schemes.</td>
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<tr>
<td>145/2/H</td>
<td>Capital developments 1961-1971 (3 vols.).</td>
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<tr>
<td>145/2/I</td>
<td>Capital developments: priorities from HMCs.</td>
</tr>
<tr>
<td>145/2/K/9</td>
<td>Evidence to the Select Committee on Estimates. Investigation into hospital building in Great Britain (see also House of Commons, 1970).</td>
</tr>
<tr>
<td>194</td>
<td>Development of hospital services on Teesside (4 vols.).</td>
</tr>
<tr>
<td>195</td>
<td>Medical planning of hospital services - Newcastle (7 vols.).</td>
</tr>
</tbody>
</table>
2.3 Papers relating to hospital planning since 1974.

2.3.1 Files of Newcastle AHA(T).

The examination of hospital developments in Newcastle upon Tyne (see Chapter 7) drew upon the Minutes and Meeting Papers of Newcastle AHA(T) for 1974-1982, and upon miscellaneous unpublished documents referenced separately.

2.3.2 Papers held by the Northern RHA.

The following files were consulted:

<table>
<thead>
<tr>
<th>RHA File</th>
<th>Subject</th>
</tr>
</thead>
<tbody>
<tr>
<td>A9/422</td>
<td>Sunderland AHA-Planning.</td>
</tr>
<tr>
<td>86/51</td>
<td>Capital Development Programme.</td>
</tr>
<tr>
<td>529</td>
<td>Resource Allocation.</td>
</tr>
</tbody>
</table>

In addition, the account of hospital planning in the Sunderland area (Chapters 9, 10) drew heavily on papers held in a file entitled Sunderland AHA-Major Development, held in the Planning Department, Northern RHA. Documents pertaining to the study of hospital planning in the Durham AHA (Chapter 10), and to recent developments in hospital policy (Chapter 7) were also consulted in the RHA's Planning Department.

2.3.3 Other sources.

Papers and minutes of the Newcastle and Durham CHCs were consulted on specific issues (e.g. on hospital closures in Newcastle - see Chapter 7).

3. Miscellaneous sources

The Newcastle Central Library's collection of press cuttings on hospitals and health services (nine volumes, 1969
to date) was valuable in supplementing the account of hospital development in Newcastle. Tyne Wear Archives Department holds records of the Board of Governors of the RVI; those concerning proposals for post-World War II hospital development in Newcastle were consulted.

4. Data on the location and size of hospitals.

These were obtained, first, from the Hospital Surveys (Ministry of Health, 1946, volumes 9 and 10). These gave descriptions of the location, size, former ownership, and staffing of all hospitals in the Newcastle RHB area. Details of the location of individual hospitals were checked against the OS 1" (Sixth Series) maps and against more detailed maps as and where appropriate; street atlases were used to check hospital sites on Tyneside, Wearside and Teesside. Subsequently, information on hospital size was obtained from the Annual Accounts of Newcastle RHB, and the location of hospitals was checked against the addresses given in the Newcastle RHB's handbook on Grouping of Hospitals, published in 1962. This was necessary because a number of hospitals either changed their name, merged with other facilities, or were taken over by the Ministry of Health some time after 1948. Thus the St. Mary Magdalene Home for Incurables, Newcastle, became the Hunter's Moor Hospital; the Sheriff Hill Hospital (Gateshead) merged with the adjacent Queen Elizabeth Hospital as development proceeded at the latter; and the former Dunston Hill War Pensioners' Hospital (in Gateshead HMC) was taken over by the NHS in 1957.