From cottage to community hospitals: Watlington Cottage Hospital and its regional context, 1874–2000

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Abstract

The appearance in England from the 1850s of 'cottage hospitals' in considerable numbers constituted a new and distinctive form of hospital provision. The historiography of hospital care has emphasised the role of the large teaching hospitals, to the neglect of the smaller and general practitioner hospitals. This article inverts that attention, by examining their history and shift in function to 'community hospitals' within their regional setting in the period up to 2000. As the planning of hospitals on a regional basis began from the 1920s, the impact of NHS organisational and planning mechanisms on smaller hospitals is explored through case studies at two levels. The strategy for community hospitals of the Oxford NHS Region—one of the first Regions to formulate such a strategy—and the impact of that strategy on one hospital, Watlington Cottage Hospital, is critically examined through its existence from 1874 to 2000.

Introduction

The appearance in England from the 1850s in considerable numbers of what, from the beginning, were termed 'cottage hospitals' constituted a new and distinctive form of hospital provision. The number of these small general practitioner hospitals grew steadily up to 600 at the beginning of the Second World War, but from around 1930 they faced two successive challenges. First, they had to respond to the attempts to rationalise hospital provision within the emerging but shifting concept of population-based health care regions, leading to the regionalised and centrally funded National Health Service. Then, renamed as community hospitals, they needed to find a positive role in modern high-technology medicine.

Cottage hospitals have been neglected by social and medical historians. Only two major publications have appeared in the last 20 years, one a detailed narrative history written by the founder of the Association of Cottage Hospitals, and one academic publication focusing on cottage hospitals in East Anglia up to 1948.[1] Until the last 20 years a major

1 A key detailed source is M. Emrys-Roberts, *The cottage hospitals 1859–1990* (Motcombe, Tem, 1991).

Dr Meyrick Emrys-Roberts was himself a GP who had worked in cottage hospitals, and he was also founder of the Association of General Practitioner Hospitals in 1969: S. Cherry, 'Change and continuity in cottage hospitals 1859–1948', *Medical History* 36 (1992), 271–89, which focuses mainly on cottage hospitals in East Anglia. See also R.M.S. McGonaghey, 'The evolution of the cottage hospital', *Medical History* 11 (1967), 128–40, which looks mainly at cottage hospitals in the South-West of England; and A.J.M. Cavanagh, 'Contribution of general practitioner hospitals in England and Wales', *British Medical Journal* 2 (1978), 34–6.

organising principle of the historiography of hospital care has been to emphasise the role of the large teaching hospitals, with the smaller and general practitioner hospitals relatively neglected in the literature on general practice.[2]

This article inverts that attention, by examining the history and function of small general practitioner hospitals within their regional setting in the period up to 2000. Within this context, the shift from 'cottage hospital' to 'community hospital' is analysed historically through two case studies: the example of Oxfordshire and the associated 'Thames Valley' region, and the case of Watlington Cottage Hospital in the context of that region. The analysis illuminates common issues in the development of cottage and community hospitals, and examines the impact of both the introduction of the NHS, and their struggle for survival within an ongoing policy vacuum.

The emergence of the cottage hospital movement in England in the mid-nineteenth century

In the mid-nineteenth century the levels of hospital provision across England were highly variable, but essentially hospitals or infirmaries took three main forms. The pattern of prestigious voluntary hospitals, special hospitals for specific groups of patients or for specific conditions, and the network of infirmaries typically provided within workhouses created under the 1834 Poor Law Amendment Act is well known.[3]

Several factors contributed to the development of a fourth form of hospital provision, which were from the beginning called cottage hospitals, characterised essentially by their focus on the local community, their small size, and by the medical staff being general practitioners, rather than specialists.[4] Technical medical advances in the mid-nineteenth century, such as the introduction of anaesthesia and antiseptic techniques, enabled surgical procedures to be carried out more widely. The Medical Registration Act of 1858 began the legitimization of a unified medical profession, improving standards of medical practice, and enabling the medical profession to promote their skills more assertively.[5]

2 For general hospitals see B. Abel-Smith, *The hospitals 1800–1948* (London, 1964); S. Cherry, *Medical services and the hospitals in Britain 1860–1939* (Cambridge, 1996). For general practice see A. Digby, *The evolution of British general practice 1850–1948* (Oxford, 1999); I. Loudon, J. Horder and C. Webster, *General practice under the National Health Service 1948–1997* (London, 1998).

3 See Abel-Smith, *The hospitals*, for an authoritative account of the development of the English hospital system up to 1948. A more recent detailed account is given in G.B. Carruthers and L.A. Carruthers, *A history of Britain's hospitals* (Lewes, 2005) which is, however, poorly referenced. For Poor Law hospitals see M.A. Crowther, *The workhouse system 1834–1929* (London, 1985).

4 Although a number of the early hospitals were known as village or local hospitals, and later as small, or general practitioner, hospitals, the term cottage hospital has persisted as the popular name for small hospitals serving mostly rural and suburban localities, with local general medical practitioners as medical staff. The term community hospital has been used more recently, but all terms continue to be used.

5 See W.F. Bynum, 'The rise of science in medicine', in W.F. Bynum, A. Hardy, S. Jacyna, C. Lawrence and E.M. Tansey eds, *The Western medical tradition* (Cambridge, 2006), 155–62 on both surgical procedures and hospital nursing.

While apothecaries in rural areas had traditionally provided both a dispensing service and a visiting domiciliary service, outside cities and large towns there were very few hospitals for those who were not paupers.[6] A dispensary was opened in 1818 at Southam in Warwickshire with four beds, and in 1827 a small hospital was opened at Piccott's End near Hemel Hempstead.[7] A number of independent initiatives then were taken from the mid-1850s. In 1854 Dr Spencer Thomson of Burton-on-Trent wrote a letter to the *British Medical Journal* on home nursing, suggesting the creation of what in function would be a cottage hospital. In 1858 an explosion at an ironworks at Middlesborough in Yorkshire prompted a local Anglican religious order to rent two cottages and convert them to a hospital.[8] Most significantly, in 1859 Mr Albert Napper, a surgeon of Cranley (now Cranleigh) in Surrey, opened what he called a village hospital with five or six beds.[9] Crucially, Napper ensured that the First Annual Report of the hospital was sent to the *British Medical Journal*, which published a leading article on his inititiative in 1860.

This article was influential because of the principles underpinning the administration of this hospital, one being that patients remained under the care of their local doctor, so that the catchment area for each hospital approximated to the areas covered by the local doctors. The other then new principle was that patients were expected to contribute financially to their care. Napper was soon to acquire a propagandist, Dr Horace Swete of Wrington in Somerset, who became an active advocate of cottage hospitals, and in 1870 published his *Handy Book of Cottage Hospitals* which gave the names of 80 foundations.[10] Together the writings of Napper and Swete created the propaganda for a cottage hospital movement, and the number of cottage hospitals grew rapidly, new hospitals being established at the rate of one a month in England from 1865, many built as memorials.[11]

There appear to have been four interlinked factors that led to the establishment of a cottage hospital: poor access to a general hospital; concerns about mortality rates in larger general hospitals; confidence by, and in, local medical practitioners; and the charitable capacity of the area. Initial costs of land and buildings were often borne by local philanthropy, as well as by considerable public donations and support in kind. While patients were expected to contribute to their own care, the costs of running a hospital were not met fully by direct patient payments or by subscriptions. Additional revenue was

6 Digby, *The evolution of British general practice.*

7 Emrys-Roberts, *The cottage hospitals*, 18–20.

8 Emrys-Roberts, *The cottage hospitals*, 29–34.

9 Emrys-Roberts, *The cottage hospitals*, 1–4: A. Napper, *The advantages derivable to the medical profession and the public from the establishment of village hospitals* (London, 1865).

10 H. Swete, *Handy book of cottage hospitals* (London, 1870). A third early advocate for cottage hospitals was Dr Edward J. Waring, who wrote a pamphlet based partly on Swete's notes.

11 For example, the Princess Alice Memorial Hospital at Eastbourne, opened in 1883 to commemorate the early death of Princess Alice in 1878, and the Queen Victoria Hospital East Grinstead, planned in 1899 and opened in 1902, a successor to three earlier cottage hospitals in the town, the first of 1863, renamed after Queen Victoria's death.

generated in a number of ways, including traditional local fund-raising events, and methods of fund-raising that were national in scope and also used by the major voluntary hospitals, such as 'Hospital Sunday' funds.

The growth of the movement in the later nineteenth century was carefully recorded by Henry (later Sir Henry) Burdett.[12] He produced a guide to cottage hospitals, the last 1896 edition of which listed 300 foundations, and which was the most comprehensive publication on cottage hospitals for nearly 100 years.[13] The number of cottage hospitals continued to grow in the early twentieth century, with increasing provision of both investigative procedures—such as X-ray machines—and of therapeutic procedures, so that typically the hospitals provided a range of services, including minor surgery, maternity care, and nursing for those who could not be accommodated at home.[14]

The adoption of the voluntary hospital model for most aspects of the management of cottage hospitals had important consequences. There was no mechanism to locate the hospitals where they would be most accessible, so by the 1930s it was apparent that the geographical distribution of cottage hospitals in England, as for other hospitals, was chaotic. It was uncoordinated, there was no overall common approach to funding, and there was no national policy framework to match numbers of beds to overall patterns of population health need—itself an unknown concept.

The impact of hospital planning on cottage and community hospitals

The consequences of the lack of any planning of hospitals were most apparent in London, and over a period of 50 years the twin principles emerged of regionalised hospital planning, and of hospital planning centred around teaching hospitals. An important first step was the establishment in 1890 of a Select Committee of the House of Lords on hospitals in London, whose report marked the beginning of a number of initiatives and reports to rationalise hospital provision, including the creation of the Prince of Wales Hospital Fund for London (now The King's Fund) which raised funds to improve the efficiency of the voluntary hospitals in London, including cottage hospitals.[15] The need to organise hospital beds for military purposes during the First World War meant that the need for cooperation between hospitals became even more apparent, so immediately after the war the Dawson Report of 1920 and the Cave Committee of 1921 considered how to

12 Henry Charles Burdett (1847–1920) became a prolific author on all aspects of hospital management. He was knighted in 1897 and was closely associated with King Edward's Hospital Fund for London: F.K. Prochaska, *Philanthropy and the hospitals of London: The King's Fund 1897–1990* (Oxford, 1992).

13 H. Burdett, *Cottage hospitals, general, fever, and convalescent: their progress, management, and work in Great Britain and Ireland, and the United States of America, with an alphabetical list of cottage hospitals* (London, 1896).

14 Emrys-Roberts, *The cottage hospitals,* 51–9.

15 *House of Lords Select Committee on Metropolitan hospitals 1890–1893, third report (321)*, iv (London, 1893); and Prochaska, *Philanthropy and the hospitals of London.*

improve liaison between the larger hospitals, and to better coordinate municipal and voluntary hospitals.[16]

These reports led to the realisation that there should be a clearer functional relationship between hospitals, with major teaching (and voluntary) hospitals being linked with other general hospitals in some form of regional structure. The 1929 Local Government Act empowered County and Borough Councils to 'appropriate' the former workhouse infirmaries, enabling progressive councils in larger cities to create municipal hospitals.[17] Another factor was the continuing growth of hospital contributory schemes as a form of private health insurance, which became a crucial element in hospital funding.[18] As the possibility of war loomed in 1938, the government created the Emergency Medical Service (EMS), which created groups of hospitals on the basis of a number of 'Regions' throughout the country.[19] The government was well aware of the poor condition of many hospitals, and so commissioned the Nuffield Foundation to conduct a survey of all hospitals in England and Wales, eventually published in 1945 as a nine-volume series of reports, based on 'Regions'.[20] Some of the volumes made general comments on the role of cottage hospitals, while others made detailed comments on individual hospitals.[21]

The passing of the 1946 National Health Service Act triggered detailed work on how best to organise the new service. England was divided into 14 Regional Hospital Boards (RHBs), related to the Regions established for the EMS. All hospitals (other than teaching hospitals), including all cottage hospitals, were organised into groups, managed by a Hospital Management Committee (HMC), typically centred around one or more larger non-teaching hospital. This hierarchical RHB and HMC structure was to remain fundamentally unchanged until 1974.

Capital spending on hospitals was limited after the war, so not until 1962 was a *Hospital Plan for England and Wales* announced, setting out a long-term strategy for hospital development centred around the large general hospitals, and a detailed region-by-region

16 Ministry of Health Consultative Council of Medical and Allied Services, *Interim report on the future provision of medical and allied services Cmnd 693* [Chairman: Lord Dawson] (London, 1920); Ministry of Health, *Voluntary hospitals and their services: final report Cmnd 1335* [The Cave Report] (London, 1921).

17 A. Levene, M. Powell and J. Stewart, 'The development of municipal general hospitals in English county boroughs in the 1930s', *Medical History*, 50 (2006), 3–28.

18 M. Gorsky, J. Mohan and T. Willis, *Mutualism and health care: British hospital contributory schemes in the twentieth century* (Manchester, 2006).

19 The continuing use but variable meaning of such terms as Region and Area and District in health planning indicates the elastic meaning of the terms, and conceals the difficulty in comparing services within fixed geographical areas over time because of these variations.

20 The Nuffield Foundation, later the Nuffield Provinical Hospital Trust, was a voluntary agency funded by Lord Nuffield that came to fulfill a similar role for the provinces as The King's Fund in London: G.. McLachlan, *A history of the Nuffield Provincial Hospitals Trust 1940–1990* (London, 1992).

21 For an overall review of these surveys see M. Powell, 'Hospital provision before the National Health Service: a geographical study of the 1945 hospital surveys', *Social History of Medicine*, 5 (1992), 483–504.

programme of major hospital reconstruction.[22] This discussed the tension between 'general practitioner beds' and 'general practitioner hospitals', and indicated for each cottage hospital the functions they were providing, assigning beds into acute, geriatric, maternity and 'other' categories. Some cottage hospitals provided beds in all three of the first categories, so were in effect miniature specialist hospitals.[23] While the *Plan* was regularly updated and continued to form the basis for hospital planning,[24] there was an implicit programme of closing what were seen to be small and inefficient hospitals, although without a clear policy with respect to the cottage hospitals.

From the early 1970s, a number of steps were taken to improve the coordination between different elements of health care. The major reorganisation of the NHS in 1974 created a new two-tier pattern of Regional Health Authorities (RHAs) broadly similar geographically to the previous RHBs. These in turn managed a number of new population-based District Health Authorities (DHAs) that integrated the previously separate hospital services, family practitioner services, and local authority health services, and for the first time enabled planning for community services to be closely yoked to the planning of hospital services. The introduction of 'GP Practice Budgets' in 1989, and the creation of Primary Care Trusts (PCTs) that both commissioned services from specialist hospitals and directly employed health care staff working in community settings, led in turn to a major shift in the traditional balance of power between medical hierarchies, with GPs and primary care agencies now having more influence and resources in planning local health care than hospital consultants.

An important conseqence of this shift has been an exploration of the two related concepts of a community hospital function and a local health centre function, examining from first principles what services can be provided locally and seeing primary care as the key point of entry into health care, countering earlier preoccupations with large general hospitals as the central focus of health care strategy and planning. These two interlocking processes from the late 1930s, of regionalisation and rethinking the role of the now community hospitals, can best be understood through case studies of both a region in England, and an individual hospital.

Two case studies: Oxfordshire and Watlington Cottage Hospital

Attempts to rationalise smaller hospital provision in Oxfordshire and the neighbouring 'Thames Valley' counties illustrate the complex processes described above. The precise

22 J. Welshman, 'Hospital provision, resource allocation, and the early National Health Service: the Sheffield Regional Hospital Board, 1947–1974', in M. Pelling and S. Mandelbrote eds, *The practice of reform in health, medicine and science, 1500–2000: essays for Charles Webster* (Aldershot, 2005), 279–301; National Health Service (NHS), *A hospital plan for England and Wales Cmnd 1604*, (London, 1962).

23 NHS, *A hospital plan*, 7.

24 NHS, *The hospital building plan: a revision of the hospital plan for England and Wales Cmnd 3000* (London, 1966).

boundaries of individual NHS Regions and their successor bodies have varied considerably since 1974, with counties moving from one Region to another, so focusing on an individual county within an English region is the only way to understand the impact of changing NHS policy over long periods of time. The Oxford Region was selected for this study since, first as the RHB and then the RHA, it was the earliest Region to formulate any clear strategy for cottage or community hospitals, from 1965 carrying out a series of studies into the role of community hospitals.[25] The history of Watlington Cottage Hospital illustrates some common issues in the governance of cottage and community hospitals.[26] More specifically the case studies illuminate at a local level two key points in the historical shift from cottage hospital to community hospital: the introduction of the NHS in 1946/1948, and the later pressures to close small hospitals in the hope of apparent efficiency gains.

A regional case study: Oxfordshire

The administrative boundaries of the historical county of Oxfordshire were unchanged from the nineteenth century until 1974, when the uplands of the Vale of the White Horse were transferred from Berkshire to Oxfordshire. The one major general hospital in Oxfordshire during this period, the Radcliffe Infirmary, was established as a voluntary hospital in 1770. The other nearest major hospital was the Royal Berkshire Hospital at Reading, opened in 1839. There were probably small dispensaries in the surrounding towns, but as elsewhere in the country little is known about them.[27] From the 1930s there were developments in the hospital system within Oxfordshire, largely due to the major medical benefactions by Sir William Morris (later Lord Nuffield), who created an Institute of Medical Research in 1930, a number of medical professorships between 1937 and 1938, an orthopaedic hospital at Headington, and lastly funded the Nuffield Provincial Hospitals Trust, which from 1938 actively encouraged cooperation between local hospitals.[28] This illustrates the significant impact that the resources of a single private individual could make to local hospital provision.

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25 J.H. Rickard, *Cost effectiveness analysis of the Oxford community hospital programme* (Oxford, 1976).

26 This hospital was selected as an example of an Oxfordshire cottage hospital because the surviving documentation held in the Oxfordshire Health Archives appeared more complete than for any other hospital in the catalogue. The primary sources include an almost complete series of Annual Reports from 1878 to 1947, House Committee minutes from 1944 to 1956, Monthly Reports from 1947 to 1961, Admission registers from 1919 to 1946, and Midwifery Registers from 1931 to 1950. Additional information, including collections of press cuttings and papers on the campaign opposing proposed closure of hospital, has been obtained from the papers of the Parker family (the family of the Earls and Countesses of Macclesfield, the 7th Earl being the Chairman of House Committee from the 1930s to 1950s) and from papers on the campaign regarding possible closure of the hospital from 1997 collected by Canon Tony Williamson (previously Chairman of Watlingtom Parish Council, and member of South Oxfordshire PCT).

27 I. Loudon, *The medical institutions of Oxfordshire* (Oxford, 1986), 7.

28 William Morris (1877–1963), later Viscount Nuffield, established a motor business in Oxford that grew to become a major local industry, and gave away over £30,000,000 in his lifetime, mostly to medical causes: P.W.S. Andrews and E. Brunner, *The life of Lord Nuffield* (Oxford, 1955).

The national survey of hospitals in England and Wales already referred to was conducted in the three counties of Berkshire, Buckinghamshire and Oxfordshire by three medical surveyors.[29] They reported on all the hospitals in the three counties, including 17 small hospitals in all, six in Berkshire, five in Buckinghamshire and six in Oxfordshire (including Watlington). Over a page was devoted in their report to a note on cottage hospitals, their future and the uses for which they were considered best fitted. While the surveyors concluded that the hospitals 'are no longer fitted for the routine performance of major operations nor for the treatment of the acute sick', they did see a future for the cottage hospitals as providing observation beds, as a base for an accident service, as a base for consultation with staff from the major hospital, as possible maternity units, and as local health centres.[30] At the time of the survey, Watlington Hospital was providing the first four of these functions.

The next detailed account of hospital provision in Oxfordshire and the adjacent counties was provided in the national 1962 *Hospital Plan* already outlined: 13 cottage hospitals are known to have existed in Oxfordshire (see Table 1).[31] The section covering the Oxford Region was divided into six areas for detailed consideration (four of which included parts of Oxfordshire).[32] The Central area included both the teaching group and the hospitals administered by the Nuffield Hospital Group, including all the cottage hospitals.[33] Importantly, the functions of these beds were also set out, all the beds being designated as acute beds, apart from at Wantage where six were maternity beds. Burford was the only Oxfordshire cottage hospital mentioned in detail, where the euphemistic phrase referred to new schemes which 'as completed, will enable better provision to be made for the work done at the following hospitals'—referring implicitly to the closure of the named hospitals.[34] There was considerable difference in the way in which the smaller hospitals were addressed in the updated 1966 *Plan* in the four geographical areas of interest.[35] In the North-Western area of the Region 'outlying small hospitals will continue as far as can be foreseen', and in the Southern area 'it is proposed to redevelop facilities in Wallingford … and Henley to provide a small number of beds for local needs'.[36] There was clearly no

29 E.C. Bevers, G..E. Gask and R.H. Parry, *Hospital survey: the hospital services of Berkshire, Buckinghamshire and Oxfordshire* (London, 1945).

30 Bevers *et al*., *Hospital survey*, 31.

31 NHS, *A hospital plan.*

32 Only the details of the cottage hospitals sited in the historic county and the future enlarged county after 1974 are discussed here.

33 The cottage hospitals in the Central area were those at Wantage (19 beds), Didcot (12 beds), Thame (19 beds), and Watlington (20 beds). Three of the other areas included the small hospitals at Chipping Norton (21 acute and 10 maternity beds), Burford (9 beds), Wallingford (18 acute beds) and Henley (21 acute beds).

34 NHS, *A hospital plan*, 176.

35 NHS, *The hospital building plan: a revision.*

36 NHS, *The hospital building plan: a revision*, 51.

Table 1 Cottage and community hospitals in the present county of Oxfordshire from 1960, with date of initial establishment (where known)

Name of hospital	Date of initial establishment
[L,ER] Abingdon Hospital	1886
[HP,L,ER] Bicester Community Hospital	1928
[HP,L,ER] Burford Cottage Hospital	1868
[HP,L,ER] Chipping Norton War Memorial Hospital	1919
[L] Cotshill Hospital	1836
[HP,L,ER] Didcot and District Hospital	1939
[ER] GP ward, Oxford Community Hospital, Headington	
[HP,ER] War Memorial Hospital, Henley-on-Thames	post WWI
[HP,L,ER] Thame Victoria Cottage Hospital	1897
[HP,L,ER] Wallingford Morrell Memorial Cottage Hospital	1879
[HP,L,ER] Wantage Hospital	1886
[HP,L,ER] Watlington and District Hospital	1873
[ER] Witney Community Hospital	unknown

Notes: [HP] Listed in Hospital Plan (1962) as at 1960,
[L] Listed in Loudon (1986) as at 1986
[ER] Listed in Emrys-Roberts (1991) as at 1990.

consistency within the Region in the way in which the function of the cottage hospitals, or their relationship with larger hospitals, was addressed.

However, the Oxford Region was in a number of ways well-resourced and well-led, made explicit in an interesting comparison with the poorly resourced and led Sheffield Region, then adjacent along the boundary between Northamptonshire and Leicestershire.[37] As a contemporary review of the Oxford Region between 1947 and 1994 indicates, the ‘idea of the community hospital was winning more and more converts within the Region’ in 1970. Research was also being carried out into the potential value of such a hospital in Wallingford, and a major Regional conference was held in 1974 to report on progress.[38] With the NHS reorganisation of 1974, a ‘Community Unit’ within the new single-county Health Authority of Oxfordshire became responsible for all of the smaller hospitals. For the first time all of the now community hospitals in the county were managed together with other community services, providing an opportunity for realistic county-wide planning.

37 Welshman, *Hospital provision, resource allocation*, for a detailed study of the arrangements within the Sheffield Region, with interesting comments on the effect of the personalities of leading Regional personnel, and with specific reference to the ‘able team’ in the Oxford Region, 285.

38 G. Everton and A. Moss, *Diary of a Regional Health Authority 1947–1994* (Oxford, 1996), 62; A.E. Bennett, ‘Evaluating the role of the community hospital’, *British Medical Bulletin*, 30 (1975), 223–37.

Further work in the Region led to a *Health Strategy for Oxfordshire 1994–1999,* which included a chapter on 'Primary care, community services and sommunity hospitals'.[39] This chapter drew out the common themes for all community services and locality development, also spelling out the implications of these themes for the 12 community hospitals in Oxfordshire, and offered a vision for community hospitals as becoming 'the hub of local community services'.[40] These honeyed words were accompanied by a statement of intent that the work of the hospitals would be monitored, leading to a specific contract for each hospital, with targets to be achieved within a fixed budget.[41]

This strategic review was replaced in 1998 by another public consultation document for the county under the then new Labour government.[42] This consultation focused specifically on community hospitals, and noted that the south and west had twice as many beds as the north of the county. Two sets of options were offered, both of which included closing Burford Hospital, and the first of which also included the closure of Watlington Hospital, both consistent with the key consideration to ensure a 'fairer' distribution of beds across the county.[43] After the public consultation, the conclusion of the Authority was unambiguous: the NHS beds at both Burford and Watlington should close.[44] What happened at Watlington both illustrates the impact of these policies at a local level, and shows how the small community hospitals in Oxfordshire had been progressively drawn into larger-scale plans in the latter half of the century.

A study of an individual cottage hospital: Watlington Cottage Hospital

In 1874 Watlington was a small market town, with no industrial development but with very substantial landed estates around the town. Like the other market towns in Oxfordshire, it changed little until after the Second World War, but unlike the two nearest market towns, Thame and Wallingford, it has remained relatively undeveloped up to the present day. In 1874 the sixth Countess of Macclesfield and her friends founded the first hospital, known formally as Watlington and District Hospital, in a still extant building in the centre of the town. It was for the 'relief of the sick and suffering' of 27 named parishes around Watlington. The administration of the hospital followed the by then standard pattern, with a committee of management appointed by the subscribers, a paid resident

39 J. McWilliam, 'Primary care, community services and community hospitals', in Oxfordshire Health Authority and Oxfordshire Family Health Services Authority, *A health strategy for Oxfordshire 1994–1999* (Oxford, 1994), 267–74. All Health Authorities were required to produce these strategies.

40 J. McWilliam, 'Primary care', 272.

41 J. McWilliam, 'Primary care', 273.

42 Oxfordshire Health Authority and Oxfordshire Community Health NHS Trust, *A strategy for reshaping community services* (Oxford, 1998).

43 Oxfordshire Health Authority, *A strategy*, 4.

44 Oxfordshire Health Authority and Oxfordshire Community Health NHS Trust, *Response to consultation on a strategy for reshaping community services* (Oxford, 1999), 23–4.

nurse and assistant, with local medical practitioners providing medical services but not involved in the management of the hospital.[45] What is not clear is why the Countess took this initial decision: neither Wallingford nor Thame, with larger populations and similar distances from Oxford, then had a hospital. Lady Macclesfield (1821–1912) was at the time Lady of the Bedchamber to the Princess of Wales (later Queen Alexandra), who had a long-term interest in medical charities, which may have been a factor in her initiative.[46]

The first existing Annual Report is for 1878, and a series of reports exists from then until the last in 1947, with few gaps. These reports portray key events, how the hospital was managed and staffed, and the pattern of activity and life at the hospital over these 70 years. They give details of clinical activity, including numbers of patients admitted from each of the neighbouring parishes, total numbers of patient days, types of cases seen, and the number of operations. The first 1878 Report showed, for example, that 21 patients were admitted, aged from 13 to 60, their conditions including 'supperation of the hip joint', accident, and delirium tremens: outcomes were given for 17, three of whom had died. Over the next few years the numbers of patient admitted each year rose, with 48 admitted in 1886 and 36 in 1890, and even a generation later the numbers were broadly similar, with 34 patients in 1917. Major and complex operations were carried out: the Annual Report for 1886 mentions an amputation of both feet, and in 1897 the surgeon, John McOscar, reported in the *British Medical Journal* the innovative treatment of hare lip with silver wire.[47]

The Rules and Regulations of the hospital set down eligibility criteria for those admitted, and regulations regarding payments and provisions.[48] Apart from subscriptions and maintenance payments, additional revenue came from a number of sources, including collections from local churches and special events, such as a concert in 1894 that raised £18. It is not clear whether there were any sponsoring arrangements for poor patients earlier in the life of the hospital. In 1878 the income for the year was £194 1s ½d, and at the end of the year the balance in hand was £13 16s ¾d. By 1890 the income was £227 1s 0d, and income remained at that level for another 25 years—in 1917 it was £245 6s 4d.

The hospital building was steadily upgraded. In 1910 one of the wards was converted into an operating theatre, in 1923 electric lighting was installed, and a maternity ward was opened in 1924. However, the building offered very limited scope for expansion, and in 1925 land and buildings at Watlington Farm, outside the town, were purchased for a new hospital, funded entirely by public donations, which opened in June 1927. In

45 This core account of the history of Watlington Hospital is taken from a short undated paper by Lynne Parker, supplemented by details from Annual Reports.

46 G. Battiscombe, *Queen Alexandra* (London, 1969).

47 J. McOscar, 'Watlington Cottage Hospital', *British Medical Journal,* 11 September 1897, 654.

48 Those suffering from infectious diseases, chronic insanity, or women in an advanced state of pregnancy, were not admitted. All patients were expected to contribute to their maintenance, paying a mimimum of 3s 6d a week: *Rules of the Watlington Hospital*, undated pamphlet.

addition to the general and maternity wards there were two private wards and an operating theatre, and two more rooms were added in 1929. An official guide to the town published around 1928/1929 refers to 'the new model cottage hospital', and a revised edition of the guide of 1965 again refers to the cottage hospital with pride as an important facility for the area.[49]

From the 1920s new sources of revenue appeared, reflecting the involvement of local residents in the Radcliffe and the Royal Berkshire subscriber schemes, and the accounts include a calculation of cost per patient day, as well as major donations. As an example during this inter-war period, the Annual Report for 1934 shows that there were 298 patients, of whom 162 were Radcliffe contributors, five Royal Berkshire contributors, and 33 private patients, the cost per patient per day being 7s 1d. Of those 298 patients, there were 155 surgical, 105 medical and 39 maternity cases, 14 of whom died. In 1938 the reports include a note on the work of the Oxford and District Joint Hospitals Board, which was founded in 1937 by Lord Nuffield to coordinate the work of local hospitals. This covered not only the major Oxford hospitals, but also seven other Oxfordshire cottage hospitals and four cottage hospitals in adjacent counties, indicating some county-wide awareness of the value of at least some form of cooperation. The Annual Reports give the number of patients treated each year in the hospital since its foundation: figures between 1874 and 1920 show no overall trend over the period, with the lowest number of 18 in 1879 and the highest of 64 in 1910. There was then a steady rise, reaching 333 in 1939, the last year before the Second World War.

Another light is put on the Annual Reports by studying the monthly House Committee Minute books. These tell of the realities of work at the hospital. There were major difficulties in recruitment of both nursing staff and ancillary staff, particularly cooks. In August 1946 it was agreed to pay domestic staff the national agreed rates, the wages bill thereafter doubling from under £200 to over £400.[50] At the same meeting it was agreed to authorise the Honorary Treasurer to make arrangements for an overdraft to pay for repairs to the building, but by February 1948 the hospital was mortgaged to the local bank.[51]

The transfer to the NHS was noted at the last meeting of the old committee on 13 July 1948.[52] On 5 July 1948—the 'appointed day'—the hospital passed into the ownership of the Ministry of Health, and the management of the hospital was taken over by the Nuffield Hospital Management Committee. Up to this point the 7th Earl of Macclesfield was both President of the Trustees and Chairman of the House Committee, being present at virtually all of the recorded meetings of the House Committee and acting as Treasurer

49 OCR DL IV/iii/9c: C.A. Wiggins, *Watlington official guide* (Watlington, undated).

50 House Committee Minutes (HCM), 12 August 1946.

51 HCM, 10 February 1948.

52 HCM, 13 April 1948.

from time to time.[53] All of these arrangements were very much in line with other cottage hospitals of the time.[54]

There was clearly ongoing strong local support for the hospital, expressed in both gifts and voluntary work, and in 1962 a formal League of Friends for the Hospital was started. Crucially for later events, this created a cohesive group of people with regular direct involvement in the work of the hospital. The League of Friends was now the group behind both the continuing substantial funding of extensions and equipment, and campaigns to prevent closure of the hospital (renamed as Watlington and District Community Hospital in 1976) from probably at least 1970. The local Watlington paper, the *Watlington Times*, published articles on threats to the hospital, and a 1978 issue also indicated who the hospital catered for: 'casualties, accidents in the home, convalescents, the infirm, elderly … enabling old folk to live in their own homes, and accommodation for old people for short stay while their caring relatives have a break'.[55] In 1994 and 1995 the Friends contributed £240,000 towards two phases of refurbishment work at the hospital totalling £410,000, showing the continuing substantial voluntary funding accepted by the NHS.[56]

The formal consultation carried out by the Region in 1998 was the culmination of a series of threats to the hospital, with vigorous responses led by the League of Friends. A small but highly experienced expert group ran an extremely effective campaign, in which local celebrities were actively involved, but the decision to shut the hospital was upheld by the Secretary of State, and the hospital closed in 2000.[57]

However, the steering group had astutely anticipated the possibility of closure and had prepared an alternative plan, which involved purchasing the site of the now redundant hospital, demolishing the old building, and building both a new health centre and a privately-run nursing home for local residents. This plan required the local community to raise the money to buy again the land originally purchased in 1925. The new facility, opened in 2003, thus continues on the same land, not perhaps a community hospital, but fulfilling a number of the functions of one.[58] Burford Hospital had the same fate, closing in 2000, but an alternative strategy had not been formulated.[59]

A footnote on the role of the hospital in the last 20 years of its life is given by the reflections of Dr Ian Neale, one of the GPs who worked there from 1980 until the closure. Unusually, he served as a member of the Health Authority during the consultations from 1998, so he

53 Wat 1 B1/1, HCM

54 Emrys-Roberts, *The cottage hospitals.*

55 *Watlington Times*, 27 September 1978, 1.

56 Parker papers.

57 *Oxford Times*, 5 November 1993.

58 Press release on opening of the new care home.

59 Lord Rotherwick, *House of Lords debate on the NHS*, Hansard, 2 February 2000.

was both a GP at the hospital and a member of the body proposing to close it. His conclusion was that the main reason for the closure of the hospital was that it was too small. The progress of clinical medicine in the sophistication of modern diagnostic technology and the increasing complexity of medical procedures meant that small community hospitals could not provide the skilled staff or facilities for them.[60]

This brief account of one cottage and then community hospital illustrates a number of features common to many of these rural hospitals. Firstly, it highlights the substantial local commitment to them over generations, arising from the affection and pride of the local community, sometimes (as here) by members of the same families. This was expressed not only in financial giving and donations in kind, but also in direct managerial involvement, voluntary work and campaigning. Secondly, it shows how successive advances in specialist medical procedures imposed limits on the hospitals in the range of clinical work they were able to carry out safely, with consequent narrowing of the range of problems they could address. Lastly, it demonstrates how managerially exposed they became, and how vulnerable they were to financially-driven review processes. Successive regional hospital planning reviews, driven by national political ideologies, were carried out by regional officers required to implement policies, such as the Griffiths Report and GP Practice Budgets, which had unanticipated consequences for the functioning of these small hospitals, which they were not equipped to counter.

Conclusion: reflections on planning small hospitals

At their peak, cottage hospitals comprised 20 per cent of all hospitals in England. By 1930 12,000 of the 73,000 voluntary hospital beds in the country were in cottage hospitals. In 1974, 46 of the 103 hospitals in the then Oxford RHB had fewer than 50 beds.[61] They were key elements of healthcare provision for rural areas for well over 100 years, with a close linkage between the hospital and the population they served, in Watlington's case specified originally in terms of linked parishes. From 1860 until around 1930 most cottage hospitals grew according to local circumstances. Most were in small towns addressing largely rural and local need—as in Oxfordshire, and in East Anglia and the South-West of England, the two other areas where detailed studies of cottage hospital have been carried out.[62] In more industrialised areas cottage hospitals were specifically intended to meet particular work-related conditions, as illustrated by the Palmer Memorial Hospital at Jarrow, built by Charles Palmer as a memorial to his wife Jane as an accident hospital for his extensive shipyards and iron works.[63] Since 1930 a number of factors profoundly

60 Interview with Dr Ian Neale at Chalgrove Barn Surgery, 28 April 2008.

61 R. Rue, 'Concept', in A.E. Bennett ed., *Community hospitals: progress in development and evaluation* (Oxford, 1974), 3.

62 See Cherry, 'Change and continuity', and McGonaghey, 'The evolution of the cottage hospital'.

63 J. Cuthbert and K. Smith, *Palmers of Jarrow* (Newcastle on Tyne 2004), 22–3.

affected their survival: the growth of contributory schemes, the creeping arrival of regionalisation via the Emergency Medical Service and the Nuffield hospital surveys, the arrival of the NHS, and ultimately the vagaries of constantly shifting and sometimes inconsistent hospital planning processes.

The shifts from the original concept of a cottage hospital to a latter-day community hospital can be approached from several perspectives. One perspective is as a conventional historical narrative, the tradition in which the valuable work of Emrys-Roberts falls.[64] Another perspective is to adopt a public history view, seeing them as part of local history, and emphasising, correctly, their place in local life and affection: most of these local historical accounts are not analysed within their NHS organisational context.[65] A third, developmental, perspective would examine the long-term 'career' of individual hospitals, or groups of hospitals, and their relationship to the surrounding communities.[66] Some of the original small hospitals grew in size and survived to become general or specialist NHS hospitals, some continued as community hospitals, others became generic or specialist nursing homes, and some closed—as illustrated by the Oxfordshire examples.

These shifts are not confined to the changing role of hospitals alone. As already discussed, a remarkable new principle of the cottage hospital movement was that patients were expected to pay—a contrast to the then dominant models of provision by charity or the Poor Law. Those people who used the growing number of cottage hospitals were themselves contributing to the shifting relationship between private philanthropy, self-funding and state provision that characterised the emergence of a mixed economy of welfare. A regional study (in East Anglia) of the impact of voluntary contributory schemes, including those incorporating cottage hospitals, suggests that the size and impact of these schemes may have been under-stated.[67] Three distinct phases in the relationship between the state and voluntary provision have been proposed, of separate spheres (1900–1914), complementary or supplementary (1918–1980, and alternative providers (post-1980s).[68] The final phase of local hospital provision in Watlington, through a private provider, itself illustrates the way in which 'the relationship between each component of the mixed economy of welfare changes over time and according to particular circumstances'.[69]

64 Emrys-Roberts, *The cottage hospitals.*

65 See, as another Oxfordshire example, M.Prentice, *Wantage cottage hospital 1886–1927*, Vale and Downland Local History Series. First published 1987; www.wantage.com/museum/Local_History/Wantage accessed 2 April 2008.

66 This is the approach taken by both Cherry, 'Change and continuity', and McGonaghey, 'The evolution of the cottage hospital'.

67 S. Cherry, 'Beyond National Health Insurance. The voluntary hospitals and hospital contributory schemes: a regional study', *Social History of Medicine* 5 (1992), 455–82.

68 J. Lewis, 'The voluntary sector and the state in twentieth century Britain', in H. Fawcett and R. Lowe eds, *Welfare policy in Britain: the road from 1945* (London, 1999), 52–68.

69 J. Stewart, 'The mixed economy of welfare in historical context', in M. Powell ed., *Understanding the mixed economy of welfare* (Bristol, 2007), 37.

Supported by the case studies, it is possible to describe three key periods of change in the organisation and function of community hospitals over the past 70 years. The first phase was between 1938 and 1948, as regional planning began within an emergent nationally planned and funded health care system. The second key phase began in 1962, as a highly centralised planning mechanism was implemented, with a nod towards regional planning. This led to the slow decline of the community hospitals by policy and funding neglect, and due to perceived inefficiencies by the criteria of the period: more recent primary care policies and evaluative criteria, emphasising the importance of ease of access and patient satisfaction, analyse inefficiencies in different and more complex ways.[70] Thirdly, from the early 1990s, a new policy interest in local community health provision has informed and revitalised the ongoing tension between the provision of high technology specialised medicine, and locally accessible and acceptable continuing care.

Another perspective, illustrated by this paper, is more analytic. Simply to describe a hospital as a cottage—or community—hospital does not describe the range of functions it exercises, or the range of the communities served by each function. These have included ante-natal and maternity care, acute medicine, long-term nursing care, convalescence after hospital care, minor operations, respite care, nursing home care—as well as other health centre and community health functions. Changes in which functions have been offered by an individual community hospital illuminate a number of complex interactions: between changing medical technologies, the practice assumptions of different groups of doctors and other clinicians, the impact of changing administrative and financial arrangements for healthcare, and changes in the size, communications and social structure of the host communities—and not least the expressed preferences of the local community. A complementary viewpoint is to see these hospitals not as part of a hospital system, but as part of general practice. However, three separate authoritative histories of general practice pay scant attention to the topic.[71]

Historically-based case studies in this field can positively illuminate both the regional organisational context within which these changes have taken place, and factors affecting the path individual cottage hospitals have followed through this period of change. However, a wider perspective is also required, taking into account the factors identified here of national planning policies and procedures, and funding mechanisms. Relying on a single regional study, or single hospital case studies, neglects the range of factors within a single county, and county- or region-wide factors that are not applicable to other counties or regions. The role of key individuals at critical points should also be taken into account, as shown by the work of Albert Napper and Sir Henry Burdett at a national level, and at a local level the equivalents of Viscount Nuffield and the successive Earls and Countesses of Macclesfield.

70 Department of Health, *Primary care and community services: improving audit in primary care* (London, 2009).

71 Honigsbaum, *The division in British medicine,* 137; Loudon et al., *General practice,* 124–6; and A. Digby, *The evolution of British general practice.*

There are several significant conclusions from this multi-layered analysis. Cottage hospitals were a significant and accessible element of healthcare provision for many rural communities in England until the 1960s and after. They had initially developed according to perceptions of need largely determined by demand from the local community, and supply from local doctors and other accessible hospitals. When active planning of hospitals on a regional basis began in 1962 there was a policy void around the role of smaller hospitals.

The later kaleidoscope of shifting boundaries and funding mechanisms has offered no consistency of local healthcare provision to the communities served by these hospitals, historically fragile both financially and organisationally. Planners—and historians—of hospitals have seen the large teaching hospitals as both exemplars of high quality clinical hospital care and as the organisational focus of hospital planning, without adequately considering alternative perspectives. Academic medical historians have neglected these small hospitals, and while local historians are now paying them extensive attention, this is without any policy, population-based or regional context.

The homely term 'cottage hospital' has endured. It is today still consciously used as a rallying cry to encourage a clearer primary care focus and community orientation in community hospitals, seeing the new focus on managing chronic disease as 'the kiss of life' for the cottage hospitals that still remain.[72] Perhaps at long last explicit policy will be matched by adequate resources and consistent and sustained implementation.

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72 N. Summerton, 'Cottage industry', *Health Service Journal,* 114 (23 September 2004), 28–9.