

‘These Schemes Will Win for Themselves the Confidence of the People’: Irish Independence, Poor Law Reform and Hospital Provision

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Abstract: This article examines hospital provision in Ireland during the early twentieth century. It examines attempts by the newly independent Irish Free State to reform and de-stigmatise medical relief in former workhouse infirmaries. Such reforms were designed to move away from nineteenth century welfare regimes which were underpinned by principles of deterrence. The reform initiated in independent Ireland – the first attempted break-up of the New Poor Law in Great Britain or Ireland – was partly successful. Many of the newly named County and District Hospitals provided solely for medical cases and managed to dissociate such health care provision from the relief of poverty. However, some hospitals continued to act as multifunctional institutions and provided for various categories including the sick, the aged and infirm, ‘unmarried mothers’ and ‘harmless lunatics’. Such institutions often remained associated with the relief of poverty. This article also examines patient fee-payment and outlines how fresh terms of entitlement and means-testing were established. Such developments were even more pronounced in voluntary hospitals where the majority of patients made a financial contribution to their treatment. The article argues that the ability to pay at times determined the type of provision, either voluntary or rate-aided, available to the sick. However, it concludes that the clinical condition of patients often determined whether they entered a more prestigious voluntary hospital or the former workhouse. Although this article concentrates on two Irish case studies, County Kerry and Cork City; it is conceptualised within wider developments with particular reference to the British context.

Keywords: Hospital Provision, Poor Law Infirmaries, Entitlement, Irish Free State, Inter-war Health Care

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Introduction

Soon after the signing of the 1921 Anglo-Irish Treaty and establishment of the new independent southern Irish Free State in 1922 the country's new leader, W.T. Cosgrave, outlined his vision for welfare and health care. He stated that the best sign of a true civilisation was how it treated its less well off and that 'the condition of a nation's poor indicated the character of the national mind'. Speaking of the on-going poor law reform, initiated during the Irish revolution (1919–21) and continued in the early years of the Free State, Cosgrave believed that 'the new schemes ... will be administered prudently and humanely, and that these schemes will win for themselves the confidence of the people'.¹ This article concentrates on poor law hospital provision and examines the extent to which Cosgrave's claims materialised in the first decade of Irish independence.

While the poor law system in nineteenth and early twentieth century Ireland has been the focus of much recent historical research, its transformation in the post-1914 period has received limited attention.² Historical examination of medical provision in early independent Ireland has largely concentrated on administrative reforms undertaken in local government.³ These insights provide the administrative, bureaucratic and political context for understanding the development of welfare provision. However, such work does not engage in recently developed historiographical debates, particularly evident in a British context, which have yielded fresh perspectives. Recent studies have focused on voluntary and municipal authorities in inter-war Britain and concentrated on various themes including health care economics, integration of services, regional trends in standards, levels of usage and party political influence on local health care.⁴ Workhouse hospitals and poor law authorities have received less attention during this era, although recent work has explored the introduction of the 1929 Local Government Act in England and Wales, and the slow erosion of the older poor law principle of 'less eligibility' and the continued stigma associated with former poor law infirmaries.⁵ This article contextualises the Irish experience within such wider understandings of health care and medical relief.

The reforms of the poor law undertaken in the first ten years of the Irish Free State are largely viewed as a failure.⁶ One leading Irish historian, J.J. Lee, sardonically noted that

¹ Committee of Inquiry, Charles H. O'Connor (Chairman), *Report on the Commission of the Relief of the Sick and Destitute Poor, including the Insane Poor* (Dublin: Stationery Office, Saorstát Éireann [Irish Free State], 1927), 18.

² For the Irish poor law in the nineteenth and early twentieth centuries see, Virginia Crossman, *Politics, Pauperism and Power in Late Nineteenth-Century Ireland* (Manchester: Manchester University Press, 2006); *ibid.*, *Poverty and the Poor Law in Ireland, 1850–1914* (Liverpool: Liverpool University Press, 2013); Peter Gray, *The Making of the Irish Poor Law, 1815–43* (Manchester: Manchester University Press, 2009).

³ Ruth Barrington, *Health, Medicine and Politics in Ireland, 1900–70* (Dublin: Institute of Public Administration, 1987); Mary E. Daly, *The Buffer State: The Historical Roots of the Department of Environment* (Dublin: Institute of Public Administration, 1997).

⁴ Alysa Levene, Martin Powell, John Stewart and Becky Taylor, *Cradle to Grave: Municipal Medicine in Interwar England and Wales* (Oxford: Peter Lang, 2011); Becky Taylor, John Stewart and Martin Powell, 'Central and Local Government and the Provision of Municipal Medicine, 1919–39', *English Historical Review*, 122 (2007), 397–426; Martin Gorsky, John Mohan and Martin Powell, 'The Financial Health of Voluntary Hospitals in Inter-War Britain', *Economic History Review*, 4, 3 (2002), 533–57; Martin Gorsky and Sally Sheard (eds), *Financing Medicine: The British Experience since 1750* (London: Routledge, 2006); Barry Doyle, 'Labour and Hospitals in Urban Yorkshire: Middlesbrough, Leeds, and Sheffield, 1919–38', *Social History of Medicine*, 23, 2 (2010), 374–92.

⁵ Alysa Levene, 'Between less eligibility and the N.H.S.: The changing place of Poor Law Hospitals in England and Wales, 1929–39', *Twentieth Century British History*, 20, 3 (2009), 322–45.

⁶ For an outline of the historiography of Irish hospitals to date see, Catherine Cox, 'Institutionalisation in Irish History', in Catherine Cox and Maria Luddy, *Palgrave Advances in Irish History* (Basingstoke: Palgrave

these measures merely substituted an ‘odious and foreign scheme’ with an ‘odious and native’ one.⁷ The financial insecurity of the nascent Irish Free State meant that health care and welfare were of secondary importance to cementing national independence. Also, the achievement of ‘economies’ and fiscal liberalism influenced the policies of the Cumann na nGaedheal government.⁸ This contrasted with the Fianna Fáil government that came to power in 1932 and prioritised welfare reform.⁹ It also oversaw the development of Irish hospitals with finance raised through the Irish Hospitals’ Sweepstakes lottery.¹⁰ However, the break-up of the poor law system under the Cumann na nGaedheal government did represent a significant attempt at reform and predated the introduction of similar measures in the UK. The reforms amounted to the first formal break from the New Poor Law that was established initially in England and Wales in 1834 and in Ireland in 1838.

This article also concentrates on voluntary hospitals. The 1920s witnessed growth in patient fee-payment for hospital provision in Great Britain and Ireland. It has previously been highlighted that accessibility for the sick non-paying poor to such hospitals was at times limited.¹¹ This article examines how fee-payment influenced entitlement to voluntary health care and led to a demarcated system between the voluntary hospitals and former workhouse infirmaries. Such explorations contribute to understandings of not only the Irish case but also to the wider comparative literature on Great Britain and Western Europe.

Workhouse Infirmaries in Pre-independent Ireland

Irish Poor Law medical provision was transformed under the 1862 Poor Law Act, which opened Irish workhouse infirmaries to the general sick poor and no longer confined them to the destitute classes.¹² The act essentially established a hospital service for the poor law dispensary system that was set-up initially in 1851 and provided outdoor medical relief to the Irish poor.¹³ The network of over 150 workhouses ensured that poor law infirmary

Macmillan, 2010), 169–90; Elizabeth Malcolm, ‘Hospitals in Ireland’, in *The Field Day Anthology of Irish Writing: Irish Women’s Writing and Traditions* (Cork: Cork University Press, 2002), 705–11.

⁷ Joseph J. Lee, *Ireland, 1912–85: Politics and Society* (Cambridge: Cambridge University Press, 1989), 124. Lee paraphrased the 1919 Democratic Programme which was read out at the First Dáil (then the Irish revolutionary parliament) and condemned the poor law.

⁸ Barrington, *op. cit.* (note 3), 89–112; Sophia Carey, *Social Security in Ireland, 1939–52: The Limits to Solidarity* (Dublin: Irish Academic Press, 2007), 33; Mel Cousins, *The Birth of Social Welfare in Ireland, 1922–55* (Dublin: Four Courts Press, 2003), 29–58.

⁹ Cousins, *op. cit.* (note 8), 56–88.

¹⁰ Maria Coleman, *The Irish Sweep: A History of the Irish Hospital Sweepstakes, 1930–87* (Dublin: University College Dublin Press, 2009).

¹¹ Mary E. Daly, ‘An atmosphere of sturdy independence: the state and the Dublin hospitals in the 1930s’, in Elizabeth Malcom and Greta Jones (eds), *Medicine, Disease and the State in Ireland, 1650–1940* (Cork: Cork University Press, 1999), 235–40.

¹² For an outline of the emergence of the act and development of medical relief, see Ronald Drake Cassell, *Medical Charities, Medical Politics: The Irish Dispensary System and the Poor Law* (Woodbridge: Royal Historical Society, 1997), 78–109; Catherine Cox, ‘Health and welfare in Enniscorthy, 1850–1920’, in Colm Toibin (ed.), *Enniscorthy: A History* (Wexford: Wexford County Council Public Library Service, 2010), 268; Donnacha S. Lucey, ‘Medical relief and workhouse infirmaries in the late nineteenth century: a case study of the Westport Poor Law Union’, in Carla King and Conor McNamara (eds), *The West of Ireland: New Perspectives on the Nineteenth Century* (Dublin: The History Press, 2011), 117–35.

¹³ For the emergence of the dispensary system see, Laurence M. Geary, *Medicine and Charity in Ireland, 1718–1851* (Dublin: University College Dublin Press, 2004); Ann Daly, ‘Medical victories: the Dublin Medical Press and the medical charities debate, 1838–51’, in Virginia Crossman and Peter Gray (eds), *Poverty and Welfare in Ireland 1838–1948* (Dublin: Irish Academic Press, 2011), 177–88.

provision far exceeded the other types of hospitals, mainly the county/city infirmaries and the voluntary hospitals. This was demonstrated in the 1906 Vice-Regal Commission on the poor law in Ireland. Between December 1904 and November 1905 workhouse infirmaries admitted a total of 79,800 patients. Of this figure 33,836 cases were classified as acute, 21,427 as chronic and 2,366 received midwifery services. Surgical attention was needed in 22,178 cases.¹⁴ 6,446 cases were tuberculosis or phthisis patients and another 5,635 received treatment for infectious diseases in workhouse fever wards.¹⁵ This greatly exceeded the number that attended county/city infirmaries, which were the second most prominent type of Irish hospital. During 1905 county/city infirmaries treated 15,489 medical cases of which the vast majority were acute and a mere 917 chronic patients.¹⁶ By the early twentieth century workhouses were central to the Irish poor's health care and provided much of the acute, chronic and surgical medical services in local communities.

Although the poor law in Ireland was traditionally viewed unfavourably, advances were evident in the standard of care in many workhouse infirmary wards. The controversial issue of untrained pauper and inmate nursing had begun to be addressed in 1897 after the Local Government Board issued an order forbidding the practice.¹⁷ By 1912 it was reported that 253 trained nurses and 361 sisters were engaged in workhouse nursing.¹⁸ Some workhouses in larger urban areas such as in Belfast and Waterford began to train nurses.¹⁹ By the 1910s the union infirmaries in Belfast, Cork and Galway also provided clinical training for student doctors.²⁰ The emergence of the large union hospitals as institutions for clinical instruction provided additional income from trainees' fees. Involvement in medical education also led to a deeper relationship between the poor law and the medical profession; a trend mostly associated with the more prestigious voluntary sector.²¹ Local provision, however, greatly varied and standards often depended on investment by boards of guardians. The 1898 Local Government (Ireland) Act provided poor law boards with loans for improvements to workhouse buildings from central government. Investment often determined the popularity of workhouse infirmaries within communities. The Kinsale workhouse infirmary in County Cork was considered popular amongst the poor after the local guardians upgraded the institution in the early 1900s.²² Other poor law boards, such as Westport in the poor County Mayo, failed to invest and by the 1900s many were close to dilapidation.²³ The 1898 Act also provided for the conversion of

¹⁴ *Poor Law Reform Commission (Ireland). Appendix to the Report of the Vice-Regal Commission on Poor Law Reform in Ireland*, vol. II, H.C., 1906 [Cd. 3203], 74–5.

¹⁵ *Ibid.*, 75.

¹⁶ *Ibid.*, 77.

¹⁷ The reform of nursing began in the voluntary sector and spread to the poor law system after a number of exposés undertaken by the *BMJ* in the 1890s; see Lucey, *op. cit.* (note 12), 131–4; Maria Luddy, “‘Angels of mercy’: nuns as workhouse nurses, 1861–98”, in Jones and Malcolm (eds), *op. cit.* (note 11), 102–20; Gerard M. Fealy, *A History of Apprenticeship Nurse Training in Ireland* (London: Routledge, 2006), 17–19.

¹⁸ *Annual Report of the Local Government Board for Ireland, for the Year Ended 31 March, 1912*, H.C., 1912/3 [Cd. 6339], xix.

¹⁹ *Annual Report of the Local Government Board for Ireland, for the Year Ended 31 March, 1904*, H.C., 1905 [Cd. 2320], ix.

²⁰ ‘The Medical Schools’, *BMJ*, 2, 2801 (5 September 1914), 435–47.

²¹ Margaret Anne Crowther, *The Workhouse System, 1834–1929: The History of an English Social Institution* (London: Batsford Academic and Educational, 1981), 162.

²² Donnacha S. Lucey, ‘Poor relief in the west of Ireland, 1861–1911’, in Crossman and Gray (eds), *op. cit.* (note 13), 46.

²³ Lucey, *op. cit.* (note 12), 124–34. For an outline of the negative aspects of workhouse infirmaries see, Laurence M. Geary ‘The medical profession, health care and the poor law’, in Crossman and Gray (eds), *op. cit.* (note 13), 199–201.

workhouses into district hospitals under the management of boards of governors. This effectively allowed for the separation of hospital care from the poor law. The legislation was permissive and by 1919 only a single union – Castlecomer in County Kilkenny – had introduced the measure.²⁴ Similar to British circumstances, medical services for the poor were ad hoc and variable in coverage and quality.²⁵

One of the biggest criticisms of poor law hospital provision was the mixed workhouse and infirmary model of institution. Ideologically the workhouse system was originally based on the principal of deterrence and conditions were harsh so only the truly desperate would seek relief. In theory the sick poor were not to be subjected to such principles, but in practice they had to pass the workhouse gates and often underwent stigmatising and pauperising experiences including the wearing of pauper uniforms and living under disciplined regimes.²⁶ As in England, funding for poor law infirmaries was undifferentiated from the rest of workhouse expenditure and no specific income was set aside to support the workhouse sick or fund the workhouse hospital as a separate service.²⁷ Although the more workhouse infirmaries were viewed as institutions for the sick, elderly and infirm the harder it was to justify principles of deterrence; poor law hospital services remained associated with pauperism and poverty.²⁸

The separation of medical relief from ordinary relief under the mixed workhouse and infirmary system emerged as a central aim of early twentieth century reform. Such measures were recommended by both the 1906 Vice-Regal Commission on the Irish Poor Laws and the UK-wide Royal Commission on the Poor Law and Relief of Distress, which reported in 1909.²⁹ These recommendations were not implemented although the Liberal Welfare reforms of the era – most notably the 1908 Old Age Pension and 1911 National Insurance acts – altered workhouses in Edwardian Ireland. Between 1909 and 1920 the number of daily inmates dropped from 44,027 to 25,531 (see Table 1). The category of aged and infirm, the second largest cohort in Irish workhouses, witnessed the largest decrease. This was partly brought about by the removal of the pauper disqualification for the Old Age Pension in 1909, which according to the Local Government Board ‘had a very marked effect on poor relief statistics’.³⁰ The 1909 figure of 14,427 aged and infirm decreased to 5,825 in 1920. The leading Irish economic historian, Cormac Ó Gráda, has argued that the ‘impact of the pension on workhouse admissions was of paramount importance’.³¹ Welfare measures introduced during the First World War including the separation and dependents allowances also lessened reliance on poor relief. Similarly, the wartime migration of labourers to Britain led to the ‘consequent opening for employment for the less fit’.³² The number of sick inmates also decreased – albeit at a much lower rate than the aged and infirm – from 15,602 to 13,205. By 1920, 51.3% of inmates were

²⁴ *Annual Report of the Local Government Board for Ireland, for the Year Ended 31 March, 1919*, H.C., 1920 [Cmd. 578], xxiv.

²⁵ Levene, *op. cit.* (note 5), 325.

²⁶ *Ibid.*, 324; Geary, *op. cit.* (note 23), 198.

²⁷ Keir Waddington, ‘Paying for the sick poor: financing medicine under the Victorian poor law – the case of the Whitechapel Union, 1850–1900’, in Grosky and Sheard (eds), *op. cit.* (note 4), 96.

²⁸ *Ibid.*, 103.

²⁹ For an outline of the recommendations of these commissions see, Cousins, *op. cit.* (note 8), 14–15; Geary, *op. cit.* (note 23), 202.

³⁰ *Annual Report of the L.G.B. for Ireland for the Year Ended 31 March, 1911*, H.C., 1911 [Cd.5847], xxiii.

³¹ Cormac Ó Gráda, ‘“The Greatest Blessing of All”: The Old Age Pension in Ireland’, *Past & Present*, 175, 1 (2002), 147.

³² *Annual Report of the L.G.B. for Ireland for the Year Ended 31 March, 1917*, H.C. 1917/18 [Cd.8765], xxvii.

	1909	1911	1914	1918	1919	1920
Sick	15,602	15,030	14,993	12,721	13,287	13,105
Aged and infirm	14,427	11,291	10,002	7015	5804	5825
Children	5521	5213	4601	3270	2920	2844
Lunatics, idiots and epileptics	2473	2230	2110	1720	1359	1331
Mothers having infants	749	691	570	413	353	435
All other classes	5255	4516	3942	2383	2027	1991
Total	44,027	38,971	36,218	27,522	25,750	25,531

Table 1: Categories of inmates in Irish workhouses on 31 March 1909–20. Source: These statistics are derived from the *Local Government Board Annual Reports*.

categorised as sick compared to 35.4% in 1909. The primary function of Irish workhouses had become the delivery of health care.

The 1911 National Insurance legislation was only partly introduced in Ireland. Under the Irish legislation insured workers were entitled to cash-benefits payable during sickness and a specific benefit for sanatorium treatment for tuberculosis sufferers. As in Great Britain, general hospital attendance was not included for the insured. Other restrictions on Irish insurance schemes existed. The prevalence of the dispensary system and opposition from the Irish Parliamentary Party and the Catholic Church towards increased taxation prevented the introduction of the legislation in its entirety in Ireland.³³ British medical benefits, including access to panels of doctors and medicines for the insured, were not extended and the Irish sick remained reliant on dispensary doctors or private practitioners for medical attention outside hospitals.³⁴

Reforms of the Poor Law in the Irish Free State

Momentous political events were soon to transform Ireland. The electoral rise of advanced nationalism and Sinn Féin in 1918 and the subsequent armed republican guerrilla campaign against British rule led to partition and the establishment of the independent Irish Free State and Northern Ireland, which remained in the United Kingdom. The Irish Free State brought about extensive reform of the poor law hospital service. Responsibilities for public medical services came under the newly created Department of Local Government and Public Health (hereafter DLGPH).³⁵ This process was initiated during the Irish War of Independence (1919/21) and continued after the establishment of the Irish Free State. Boards of guardians and poor law unions were disbanded and replaced by boards of public assistance and health, which were sub-committees of County Councils.³⁶ Acting along the 1906 Poor Law commission recommendations, a county home was established by each local authority for relief of the aged, infirm and chronic sick. In theory, certain categories of inmates, including ‘harmless lunatics’, ‘unmarried mothers’ and children, were to be relieved in separate institutions or boarded out; in practice these people were often relieved in county homes. County hospitals provided medical services including surgical

³³ Carey, *op. cit.* (note 8), 83.

³⁴ *Ibid.*, 103.

³⁵ This government department took over from Dublin Castle’s Local Government Board which previously administered the poor laws in Ireland.

³⁶ For an outline of the administrative reforms made by the new Free State government see, Daly, *op. cit.* (note 3), 116–24; Cousins, *op. cit.* (note 8), 29–44.

facilities for each county. Many of the previously semi-independent county infirmaries were amalgamated with workhouses under the boards of public assistance and health. A network of district hospitals was also established on former workhouse sites for emergency and less serious medical cases.³⁷ These reforms represented the first major attempt to break-up the poor law and the sector's effective municipalisation in either Great Britain or Ireland. In England and Wales significant reform was not brought about until the Local Government Act of 1929.³⁸ In Northern Ireland the 1927 recommendation of widespread poor law reform by the Departmental Commission on Local Government Administration was not forthcoming and the system remained in place until 1948.³⁹ However, a number of local authorities utilised the existing legislation and by 1938 eleven workhouses in the northern Irish state had been converted into district hospitals.⁴⁰ Others such as the Belfast workhouse had developed primarily into health care institutions and only provided limited ordinary relief to the able-bodied.

The right of the poor to medical relief in the new Irish Free State was reaffirmed. Those that were entitled to relief were defined as 'any person who is unable by his own industry or other lawful means to provide for himself or his dependents the necessaries of life or necessary medical or surgical treatment'.⁴¹ The DLGPH later claimed that the measures introduced remodelled 'the system in accordance with Irish ideas'.⁴² The department's first annual report stated that the 'main endeavour was to introduce a system of poor relief conforming to the wishes and sentiments of the people and providing efficiently and sympathetically for the needs of the poor'.⁴³ The department's leading medical advisor, Dr E.F. Stephenson, stated that the 'first aim [was] to have improved treatment for the sick poor'.⁴⁴ The Irish Free State's attempt to provide assistance free of the pauperising poor law was reflective of wider attitudes towards welfare throughout Europe. In Britain the labouring classes were increasingly viewed as an important national resource deserving of non-stigmatising provisions. Reformers such as Beatrice and Sidney Webb widely articulated the need to break-up the poor law.⁴⁵ Similar objectives were behind German reforms in the 1910s and 1920s.⁴⁶ The spread of social democracy and the

³⁷ For an outline of the reforms of the hospital system see *Report on the Commission of the Relief of the Sick and Destitute Poor*, *op. cit.* (note 1), 12; also see Daly, *op. cit.* (note 11), 22–3.

³⁸ Levene, *op. cit.* (note 5), 323; Virginia Crossman, *The Poor Law in Ireland 1838–1948* (Dundalk: Studies in Irish Economic and Social History, 2006).

³⁹ Peter Martin, 'Ending the pauper taint: medical benefit and welfare reform in Northern Ireland, 1921–39', in Crossman and Gray (eds), *op. cit.* (note 13), 223–36; *Report of Departmental Commission on Local Government Administration in Northern Ireland* (Belfast: His Majesty's Stationery Office, 1927).

⁴⁰ 'Northern Ireland Ministry of Home Affairs', *Report on the Administration of Local Government Services for the Year Ending March 1938* (Belfast: HMSO, 1938), 38.

⁴¹ Department of Local Government and Public Health, *County Order Schemes, Kerry County Scheme Order* (Dublin: Stationery Office, Saorstát Éireann, 1923).

⁴² DLGPH, *Annual Report, 1922–25: First Report* (Dublin: Stationery Office, Saorstát Éireann, 1926), 16.

⁴³ *Ibid.*, 52.

⁴⁴ *Commission on the Relief of the Destitute Sick and Poor, Including the Insane Poor; Minutes of Evidence* (Dublin: Stationery Office, Saorstát Éireann, 1925), 2.

⁴⁵ For an outline of the Webbs' influence over British welfare debates see Anthony Brundage, *The English Poor Laws, 1700–1930* (Basingstoke: Macmillan, 2002), 136–9. The Webbs still maintained deterrence-based principles in relation to those considered the undeserving and immoral poor see, Alan Kidd, 'The State and Moral Progress: The Webbs' Case for Social Reform c.1905 to 1940', *Twentieth Century British History*, 7, 2 (1996), 189–205.

⁴⁶ Larry Frohman, 'The Break-Up of the Poor Laws: German Style: Progressivism and the Origins of the Welfare State, 1900–1918', *Comparative Studies in Society and History*, 50, 4 (2008), 982.

labour movement also led to the realignment of the welfare debate.⁴⁷ The right to welfare and health care was viewed as an important aspect of citizenship in an ever increasing political community of everyday people brought about by franchise reform.⁴⁸ The rhetoric of the new Free State resonated with such transnational attempts to dilute the nineteenth-century principles of deterrence that underpinned many poor relief systems.

Despite the desire to break-up the poor law, the National Health Insurance schemes were not extended during the early years of the Irish Free State. A 1925 government inquiry recommended the introduction of medical benefit to contributors. However, such measures were not introduced in Ireland until 1942.⁴⁹ While medical benefit including insurance for hospital attendance was not compulsory, local Friendly Societies could provide such cover on a voluntary basis. In practice this measure was limited and in 1927 a mere £32,135 out of a total expenditure of £628,498 on National Health Insurance went on non-cash payments including hospital-benefit.⁵⁰ Payments for sickness, disability and maternity cases made up the vast majority of health-related expenditure under national insurance legislation in Ireland. The lack of extended medical benefits in the Irish Free State contrasted with the French experience where extensive reform was introduced with the 1928 health insurance law, which covered up to a third of the French population with hospital and sickness insurance, and in Northern Ireland where medical benefit for insured workers was also introduced.⁵¹ In southern Ireland the link between insurance and health services was weak and in contrast to Great Britain mutualism was not a major feature of Irish health care or hospital practices.⁵² The limited development of social security ensured that health care remained based on a relief-type system in southern Ireland.

Case Study of Cork City and County Kerry

To examine the effectiveness of the reforms this article concentrates on case studies of two regions – County Kerry and Cork City. County Kerry had a largely rural economy with many of its 149,171 inhabitants in 1926 dependent on agriculture.⁵³ Much of the region was economically poor – particularly along the seaboard – and marked by a small farm economy. A general unskilled labourer class was prominent in the county's towns. A more prosperous class of middle-to-large farmers in the countryside and shopkeeper/publican traders in the towns and villages was also common. After the reforms the medical services

⁴⁷ Young-Sun Hong, *Welfare, Modernity, and the Weimar State, 1919–33* (Princeton, NJ: Princeton University Press, 1998).

⁴⁸ George Finlayson, *Citizen, State, and Welfare in Britain, 1830–1990* (Oxford: Oxford University Press, 1994), 165–6.

⁴⁹ Cousins, *op. cit.* (note 8), 43–4, 142. Although a universal N.H.S. style health care system did not emerge in Ireland, general hospital services were made free to around eighty per cent of the population under the 1953 Health Act, see Brendan Hensey, *The Health Services of Ireland* (Dublin: Institute of Public Affairs, 1979), 25.

⁵⁰ Other non-cash benefits included cover for dental treatment, building or leasing of convalescent homes, medical and surgical appliances, optical treatment and appliances, and service of nurses to members, see *Report on the Administration of National Health Insurance in all Ireland from 1 April 1921 to 31 March 1922: Saorstát Éireann from 1 April 1922 to 31 March 1928* (Dublin: Stationery Office, Saorstát Éireann, 1928), 19.

⁵¹ For the far-ranging impact of this legislation see Timothy B. Smith, 'The Social Transformation of Hospitals and the Rise of Medical Insurance in France, 1914–43', *The Historical Journal*, 14, 4 (1998), 1055–87, and *Creating the Welfare State in France* (Quebec: McGill-Queens, 2003); Martin, *op. cit.* (note 39).

⁵² For the prominent role of mutualism in British hospital provision see, Martin Gorsky, John Mohan, Tim Willis, *Mutualism and Health Care: British Hospital Contributory Schemes in the Twentieth Century* (Manchester: Manchester University Press, 2006).

⁵³ *Statistical Abstract* (Dublin: Stationery Office, Saorstát Éireann, 1931), 4.

in Kerry consisted of the county hospital in the largest town, Tralee, which was on two separate sites and a combination of the former workhouse infirmary (acute and chronic cases) and the former county infirmary (surgical cases). District hospitals were established solely for non-surgical medical cases in the towns of Dingle, Kenmare, Listowel and Caherciveen; all former workhouse buildings. The district hospital in Killarney was also the county home, which acted as a centralised institution for ordinary relief cases.⁵⁴ There was not a large enough middle-class to sustain any general or specialist voluntary hospitals in Kerry besides a small cottage hospital on the remote Valentia Island. Large voluntary hospitals did exist in the neighbouring cities of Limerick and Cork and the sick from Kerry – particularly those that could afford travel costs and medical fees – often attended these hospitals.

Cork was the second largest city in the Irish Free State. The Cork County Borough had a population of 76,673 and the county in general had 365,747 inhabitants in 1926. As in most Irish and British provincial cities, a well-established voluntary hospital sector existed in Cork. Specialist institutions included a maternity and lying-in hospital; an eye, ear and throat hospital, and a fever and recovery hospital. General voluntary hospitals in the city included the Mercy, which was controlled by the Catholic religious Mercy Order, and the Victoria Hospital whose origins lay in the Protestant philanthropic tradition. Other general hospitals included the North Charitable Infirmary and the South Charitable Infirmary; these were semi-voluntary and received an annual grant from local government although the majority of their income came from charitable sources and they remained independently controlled. The total number of voluntary hospital beds in the city was circa 800.⁵⁵ The former workhouse and local authority institution – renamed the Cork County Home and District Hospital – was the largest hospital in the city and had 800–900 sick beds.⁵⁶ Many of these were for chronic long-term patients and it was estimated that merely 150 beds were designated for the acute sick.⁵⁷ The institution also acted as the county home and provided for 400 individuals in receipt of ‘ordinary’ relief. The Cork District Hospital and County Home was one of the largest institutions in the country and provided medical and poor relief to a daily average of around 1,200 people.⁵⁸ The centrality of the former workhouses to the life and death of the sick poor was demonstrated in 1926 when 18.5% of all deaths in Cork City were recorded in the institution. At a national level the rate was 14.6%.⁵⁹ In both County Kerry and Cork City the reformed poor law was the largest provider of hospital provision.

These case studies provide examples of the development of health care in two differing contexts. Cork City allows for an examination of an urban region that has not received attention to date. The large voluntary sector in the city provides insights into issues including the relationship between rate-aided and charitable hospitals; entitlement to and

⁵⁴ For an outline of the reforms in Kerry see, *Report on the Commission of the Relief of the Sick and Destitute Poor*, *op. cit.* (note 1), 31–2.

⁵⁵ *The Hospitals Commission: First General Report, 1933–4* (Dublin: Stationery Office, Saorstát Éireann, 1939), 98–9.

⁵⁶ On the 31st March 1930 there were 871 patients listed as sick in the hospital, see DLGPH, *Annual Report, 1929–30* (Dublin: Stationery Office, Saorstát Éireann, 1931), 239.

⁵⁷ Evidence of Dr Clinch before the Commission of the Relief and Sick Destitute Poor, Including the Insane Poor [hereafter, CRSDPIP], 1926, unpublished minutes of evidence, Folder 03. 0/00100A, Houses of the Oireachtas Library, Dublin.

⁵⁸ Cork County Home and District Hospital Indoor Registers, 1925/6 [hereafter, CCHDHIR], CCH/GA/3–5, Cork County and City Archives.

⁵⁹ *Register General's Annual Report 1926* (Dublin: Stationery Office, Saorstát Éireann, 1927), 28, 44.

accessibility of voluntary hospitals, and the place of fee-payment in Irish health care. Cork City was representative of other urban areas in Ireland including Limerick and Dublin and many provincial British cities, which had both poor law and voluntary hospitals. County Kerry provides an example of a largely rural county where limited voluntary hospital provision existed; the county illustrates the challenges to health care development not only in the Irish countryside, but also in less densely populated and poorer rural regions generally.

Although a major objective of the reforms was to separate medical and hospital services from ordinary relief, the mixed workhouse and infirmary model continued in the institutions designated as county homes and district hospitals. Able-bodied inmates were removed from county homes, yet the institutions continued to provide for the the aged and infirm; children, and the destitute mentally ill or 'lunatic class'. In Cork the lack of classification was highlighted during the government commission on poor relief which published its findings in 1927 [hereafter this will be referred to as the Commission of Sick Poor].⁶⁰ The Commission of the Sick Poor complained that the Cork district hospital and county home was not divided into definite and distinct parts.⁶¹ The lack of segregation between medical and ordinary cases blighted the system not just in Cork, but in many parts of the country and it continued into the 1930s. In 1935 a government inspector complained: 'generally it can be taken that the infirmary ... is administered as an integral part of a county home'.⁶² The same report highlighted that in Cork the 'sick beds were scattered throughout the whole county home accommodation'.⁶³ Lone female parents or 'unmarried mothers' who were viewed as immoral continued to be relieved in such institutions. As a result many women refused to use the maternity services in the mixed county home and district hospitals.⁶⁴

In County Kerry, the county home and district hospital in Killarney were in the same building. The separate parts were merely divided by a ward system and makeshift partitions. However, the vast majority of inmates were in receipt of ordinary relief and on 31 March 1930 only thirty-one of the institution's 441 residents were medical patients. Unlike the situation in Cork City, the majority of local authority medical cases in Kerry were not relieved in mixed hospitals and county homes; on the above date 199 patients were in district/county hospitals that catered solely for medical cases.⁶⁵ Countrywide the picture was somewhat varied. In Waterford the county home was a separate institution and not connected to any hospital and in Tipperary and Westmeath the county hospital and home were in the same building.⁶⁶ The lack of classification had long been a problem in workhouses and the reforms of the Free State failed to eradicate the issue where the county home and district hospital were contained in the same institution.

The precarious financial position of the new state after the upheaval of the Irish war of independence and civil war limited central government funding for the development

⁶⁰ The Commission of the Relief of the Sick and Destitute Poor Including the Insane Poor was held over a period of nineteen months during 1925 and 1926 and had thirty-two days of public evidence, see *Report on the Commission of the Relief of the Sick and Destitute Poor*, *op. cit.* (note 1).

⁶¹ *Ibid.*, 27.

⁶² *The Hospitals Commission Second General Report 1935 & 1936* (Dublin: Stationery Office, Saorstát Éireann, 1937), 58.

⁶³ *Ibid.*, 58.

⁶⁴ Sandra McAvoy, 'The regulation of sexuality in the Irish Free State', in Jones and Malcolm (eds), *op. cit.* (note 11), 259.

⁶⁵ DLGPH, *Annual Report*, *op. cit.* (note 56), 239.

⁶⁶ *Report on the Commission of the Relief of the Sick and Destitute Poor*, *op. cit.* (note 1), 42–9.

of local medical services. The ‘troubles’ also left local government bodies with a fresh financial crisis and undermined the ability of local authorities to raise finance.⁶⁷ Many of the county and district hospitals were originally nineteenth-century structures and conditions were decrepit. In 1927 the chairperson of the Kerry Board of Assistance and Health, Kate Breen, believed that the county hospital for all non-surgical cases – formerly the Tralee workhouse – was ‘the most struggling and most miserable place she had ever seen’.⁶⁸ Similar conditions existed in other parts of the country. In Waterford City the Commission of Sick Poor reported that the ‘county hospital is located in a cheerless environment of old dilapidated structures’, and that the county hospital in Roscommon ‘cannot be deemed a suitable place for the treatment for the sick’.⁶⁹ In other areas conditions were somewhat better and county hospitals in Galway, Meath and Wexford were highlighted for praise in the commission’s report. Similar to previous experiences under the poor law; local and regional variation marked the standard of rate-aided medical care.⁷⁰ Overall the lack of substantial financial investment in former workhouse buildings hindered the development of these hospitals during the 1920s.

The most successful measure adopted in the Free State reforms was the reduction of non-medical classes in the former workhouses. On 1 October 1913, 26,761 inmates were recorded as resident in workhouses in the twenty-six counties that would become the Irish Free State. By 31 March 1927 this was reduced to 17,281 and the number on outdoor relief increased from 14,663 to 23,649.⁷¹ Such a shift suggests that former workhouse inmates were now in receipt of assistance in their homes. The reforms helped to increase the popularity of the county and district hospitals. Notwithstanding the continued mixing of classes in some institutions, the majority of local authority hospitals were now designated solely for medical and surgical cases. Between 1926 and 1929 the annual number of patients rose from 51,880 to 58,105 indicating the system’s gradual growth.⁷² In County Kerry this trend was apparent. During 1924 a total of 1,899 admissions were recorded in the six Kerry hospitals. By 1927 this had increased to 2,385 and by 1930 2,710.⁷³ Hospitals which provided solely for the acute sick witnessed the largest increase. The county hospital in Tralee had a rise in admissions from 757 in 1924 to 912 in 1930. Similarly the Caherciveen District Hospital witnessed an increase from eighty-one to 172 patients, and the Listowel District Hospital from 238 to 250. These institutions provided acute care and longer term chronic patients were transferred to the county home. In contrast to these trends, the Killarney District Hospital, which was on the same grounds as the Kerry County Home, witnessed a decrease from 425 admissions in 1924 to 299 in 1930.⁷⁴ These figures demonstrate that the mixed hospital/county home type of institution was

⁶⁷ For an outline of financial problems of local authorities including the late of rate payment during this period see, Daly, *op. cit.* (note 3), 69–86.

⁶⁸ *The Kerryman*, 26 November 1926.

⁶⁹ *Report on the Commission of the Relief of the Sick and Destitute Poor*, *op. cit.* (note 1), 47, 41.

⁷⁰ *Ibid.*, 19.

⁷¹ DLGPH, *Annual Report, 1932–3* (Dublin: Stationery Office, Saorstát Éireann, 1934), 136.

⁷² DLGPH, *Annual Report, 1925–7* (Dublin: Stationery Office, Saorstát Éireann, 1928), 118; DLGPH, *Annual Report, 1928–9* (Dublin: Stationery Office, Saorstát Éireann, 1930), 110. After 1929 the annual reports cease to give the total number entering such institutions.

⁷³ Kerry Board of Health and Public Assistance [hereafter, KBHPA]; statistical returns. Organisations and services and finance for the years ended March 1923 to March 1932, Kerry County Library [hereafter KCL], KBH/B 42.

⁷⁴ *Ibid.*

increasingly unattractive while the other hospitals, which removed all classes of patient besides the acute sick, witnessed a modest growth in numbers.

In County Kerry the district and county hospitals had become somewhat disassociated from the relief of poverty (Killarney notwithstanding) and had the delivery of health care as their sole function. However, in Cork the reforms appeared to have been less effective. As already highlighted, the problem of mixing various types of patients – medical, surgical, acute, chronic, mental and tuberculosis – was particularly prevalent in the Cork County Home and District Hospital. An analysis of the social composition of those that entered the institution from the indoor registers reveals the continued close connection between poverty and rate-aided hospital provision.⁷⁵ Fifty-nine of the 578 patient sample had no residence demonstrating that the homeless or ‘tramp’ class – formerly known as ‘casuals’ under the poor law – still frequently turned to the institution.⁷⁶ A total of 202 patients were recorded as having some form of occupation. The vast majority (166) of this group were cited as labourers indicating that they were largely unskilled. Only twenty-two of the patients were skilled labourers or tradesmen, four were servants and the other occupations included two motor drivers and two ex-soldiers; a single nurse, engineer, merchant, fireman, civic guard (policeman) and coast guard. The majority, 332, gave no occupation on entry and these were largely females or the incapacitated poor. This indicates that the majority of patients in Cork were made up of the poorest classes in the city including the homeless and unskilled labourers. A very small number of skilled workers or middle class patients sought medical attention in the institution.⁷⁷

The length of stay of patients in the institution varied. The majority, 56.8%, stayed between two and thirty days and 8.6% stayed twenty-four hours or less. A substantial portion, 30.9% of the sample, remained for a period of between one and six months while 3.5% stayed beyond half a year.⁷⁸ The average length of stay was thirty-nine days. The differing periods of stay in the institution reflect its multi-functional uses, and the contrasting needs of the various categories of patient. The high prominence of short-stays indicated that many received acute medical and surgical attention along with traditional short-term ordinary indoor relief. The large proportion of longer-stay patients highlighted that the chronic, aged and infectious sick were also relieved in the institution. For many of these longer-term patients sickness and poverty went hand-in-hand.

Of the two case studies the reforms were most effective in County Kerry. The removal of all classes besides the acute sick from the county hospital and the majority of district hospitals made health care the sole purpose of these institutions. This helped to dilute past associations with pauperism and these hospitals witnessed an increase in admissions between 1922 and 1932. However, in institutions that remained connected to the county home – such as in Killarney and Cork City – the mixing of various categories remained a residual problem from the workhouse system. This limited the effectiveness of the reforms leading to a decrease in numbers in the Killarney District Hospital, and the continued predominance of the sick poor in the Cork County Home and District Hospital.

⁷⁵ This is an analysis of a sample of 578 of the patients that entered the institution throughout 1926. This sample is made up of every tenth entry in the registers. CCHDHIR, 1925–6, *op. cit.* (note 58).

⁷⁶ The commission on relief that reported in 1927 identified a number of urban institutions including Cork which continued to provide institutional relief for the ‘tramp’ class during this period, see *Report on the Commission of the Relief of the Sick and Destitute Poor*, *op. cit.* (note 1), 17.

⁷⁷ CCHDHIR, 1925–6, *op. cit.* (note 58).

⁷⁸ *Ibid.*

Fee-paying Patients and Changing Notions of Entitlement to Health Care

One of the most significant aspects of the Free State reforms was the amalgamation of the county infirmary and workhouse infirmary systems. Prior to Irish partition thirty-four county/city infirmaries and fourteen county fever hospitals existed. They were run by independent boards of management whose membership included representatives from the county or borough council who partly funded them, and leading local figures such as the clerical hierarchy and charitable subscribers. These institutions did not suffer from the taint of the workhouse and were not associated with destitution; they were acute surgical hospitals and did not provide for the long-term chronic sick. Under the Free State reforms many of these hospitals' boards of management, including that of the Kerry County Infirmary, were disbanded and authority was placed fully in the hands of local authorities. Such amalgamations represented the expansion of local authority and state health care into a system which was previously largely voluntary. Some city infirmaries including the North and South Charitable Infirmaries in Cork and the Waterford County and City Infirmary maintained their independence from the state.

The merging of these infirmaries with local authority health care brought the issue of patient payment for medical treatment to the fore. Entitlement to medical relief under the poor law was poorly defined. Under the 1862 Act patients deemed capable had to make some financial contribution towards their care in workhouse infirmaries, although the vast majority of patients were too poor to pay. Workhouse medical officials did not receive payment directly from patients. Contrastingly, payment was common in county infirmaries where the leading medical official – the county surgeon – was often part-time and supplemented his income through patients' fees and private practice. County infirmaries were generally viewed as hospitals for the 'higher class of wage earner' who could afford to contribute to their medical treatment.⁷⁹

The reforms of the early 1920s reaffirmed attempts to extract payment from patients. In Kerry on 12 June 1924 a mere seven patients in the county's hospitals contributed to their maintenance.⁸⁰ The DLGPH wrote to the Kerry board complaining that

there is no machinery devised by which paying patients may be determined, and a large number of patients of each of the hospitals in the county can contribute towards their maintenance when they avail of treatment in our hospitals . . . patients are sent to our hospitals as the patients of private doctors.⁸¹

Consequently, the department advised that patients be classed on the basis of the valuation of their property in rural areas and wages, salaries and businesses in urban areas.⁸² The department insisted on means-testing and informed local officials that they should be satisfied 'that patients being attended . . . are unable to afford the cost of their maintenance either wholly or partially' and the clerks of each hospital were informed 'to inquire into the circumstances of each patient on admission and to keep a separate register of those who could afford to pay'.⁸³ In Listowel town, County Kerry, attempts were made to get payment from former patients in the district hospital. Fees ranging from £1 4s to

⁷⁹ *Commission on the Relief of the Destitute Sick and Poor, Including the Insane Poor...Evidence, op. cit.* (note 44), 2.

⁸⁰ 12 June 1924, KBHPA minute book, KBH/A2, KCL.

⁸¹ *Ibid.*

⁸² *Ibid.*

⁸³ 17 July 1924, *op. cit.* (note 80). The Kerry Board of Public Assistance and Health was dissolved and a paid government official was appointed to run the system in the county for much of the 1920s.

£37 15s were demanded and legal action was threatened against defaulters.⁸⁴ Recipients of medical relief in the Free State were subject to fresh means-testing and the emphasis was placed on the payment of medical treatment where possible.

The focus on fee-payment altered the nature of hospital provision provided by local authorities. In 1925 the DLGPH introduced regulations to govern the place of fee-paying patients in local authority hospitals. Under the order 'County Hospital (Paying Patients) Regulations' three categories of patients were to be treated in different wards; those who could contribute fully, those who could contribute in part and those who could not contribute at all. Doctors could also arrange private fees for patients in local authority hospitals, which was not the case under the poor law. Patients could pay for any extras including special nursing, medicines and appliances. This allowed for separate medical provision for patients willing to contribute to their treatment although it was stipulated that if full the poor would get preference.⁸⁵ These measures were previously called for by the medical profession and the Irish Committee of the British Medical Association.⁸⁶ These reforms also provided for different groups that increasingly turned to hospitals for health care. Private patients in private wards were an emerging patient category not just in Ireland but in other countries including Great Britain. This middle-class group was able to pay full medical fees and was catered for in the reformed system. Those who could pay in part were a second group: in urban regions most probably insured skilled workers in regular employment and small farmers and land owners in the countryside. The third cohort remained entitled to free medical care; these included the impotent poor, the unemployed, and unskilled and agricultural labourers.

The motivations behind the introduction of fee-paying wards were outlined by the DLGPH's chief medical officer, Dr E.F. Stephenson, at the Commission of Sick Poor. While maintaining that the poor had 'first claim' to such hospital provision, Stephenson stated:

we think that the people whose money goes to provide those hospitals are entitled to some hospital treatment. When you ask the ratepayers to contribute large sums of money towards equipping and staffing the county hospitals they are entitled to some consideration.⁸⁷

During the commission he was asked whether these measures led to a preference for fee-paying patients and if the poor would be 'elbowed out'; Stephenson stated that he never knew of such a case. He also believed that separate private wards were necessary as they 'would avoid comparisons of dietary and treatment. The other way, the poor people will always be suspicious'.⁸⁸ However, there was some evidence that the poor were in competition with those who were willing to pay in some public hospitals. The services of the county surgeon were in high demand and the limited number of surgical beds ensured that waiting lists were reported in many regions including County Kerry. Under departmental regulations the poor had to be seen first, but one of the commissioners – Major Myles, TD (member of parliament) – was unconvinced, claiming that 'these things [preferential treatment for private patients] are difficult to get at, but these things do

⁸⁴ 24 July 1924, *op. cit.* (note 80).

⁸⁵ DLGPH, *op. cit.* (note 72), 279.

⁸⁶ 'Ireland', *BMJ*, 2, 3053, (5 July 1919), 10. However, the BMA objective of opening public hospitals to all private practitioners was not implemented.

⁸⁷ Evidence of Dr E.F. Stephenson, *Commission on the Relief of the Destitute Sick and Poor, Including the Insane Poor...Evidence*, *op. cit.* (note 44), 2.

⁸⁸ *Ibid.*, 14.

happen'.⁸⁹ In the final report the commissioners stated that they received the impression in some hospitals that paying patients were more readily received than the poor.⁹⁰

The emergence of fee-paying patients demonstrated an important transformation in the role of rate-aided hospitals and the terms of entitlement to state health care. Medical care in public institutions was no longer solely for the relief of the poor, but was also to provide a health care service to those who were capable of paying. Leading government officials articulated the rights of such patients, which amounted to preferential treatment including the receipt of quicker and separate treatment from the poor. New terms of entitlement to health care were established with the ability to pay forming important criteria which determined access. The articulation of the rights of those who contributed financially through hospital fees and taxation resonated with wider notions of the 'citizenship of contribution'.⁹¹ Those who contributed to their own welfare and to that of the community were to receive a reciprocal set of entitlements. The emergence of such 'economic reciprocalism' has been identified as an important aspect of contributory schemes in the voluntary hospital sector in inter-war Britain. Access to such hospitals was to some extent founded on the notion of earning the right to hospital treatment by means of a financial contribution.⁹² Similar concepts relating to entitlement were evident, although not dominant, in the early reforms of the Irish Free State.

Fee-Payment and Voluntary Hospitals

This section of the article concentrates on the emergence of patient fee-payment in voluntary hospitals in Cork City. Admission to the voluntary hospitals was traditionally partly confined to the 'deserving poor'. In nineteenth-century Birmingham access to the city's voluntary hospitals was often limited to individuals recommended by subscribers and those perceived as 'undeserving' and ill-behaved were occasionally denied medical treatment.⁹³ The reciprocal relationship between the receiver and benefactor of charity has been identified as a central dynamic of philanthropy. Those in receipt of such medical relief were expected to some way ascribe to the social, moral and religious norms of the boards of management and subscribers of these institutions.⁹⁴ Little if any historical work on admission policies in nineteenth-century Irish voluntary hospitals has been undertaken. However, the belief that the 'deserving poor' should receive medical relief away from the poor law was apparent throughout the nineteenth century and articulated by leading Catholic clergy such as Archbishop Cullen.⁹⁵ Entitlement to medical relief in Irish

⁸⁹ *Ibid.*, 7.

⁹⁰ *Report on the Commission of the Relief of the Sick and Destitute Poor*, *op. cit.* (note 1), 51.

⁹¹ Finlayson, *op. cit.* (note 48), 9.

⁹² George Gosling, "'Open the Other Eye": Payment, Civic Duty and Hospital Contributory Schemes in Bristol, c. 1927–1948', *Medical History*, 54 (2010), 488.

⁹³ Jonathan Reinartz, *Health Care in Birmingham: The Birmingham Teaching Hospitals 1779–1939* (Woodbridge: Boydell Press, 2009), 82; *ibid.*, 'Investigating the 'deserving' poor: charity and the voluntary hospitals in nineteenth-century Birmingham', in Anne Borsay and Peter Shapely (eds), *Medicine, Charity and Mutual Aid: The Consumption of Health and Welfare in Britain c.1550–1950* (Aldershot: Ashgate, 2007), 111–13; Steven Cherry, 'Accountability, Entitlement, and Control Issues and Voluntary Hospital Funding, c1860–1939', *Social History of Medicine*, 9, 2 (1996), 216.

⁹⁴ The subordinate role of the poor in receipt of charity has been widely focused on, see Roy Porter, 'The gift relation: philanthropy and provincial hospitals in eighteenth-century England', in Lindsay Granshaw and Roy Porter (eds), *The Hospital in History* (London, 1979), 149–78.

⁹⁵ Archbishop Cullen was highly critical of the Irish Poor Law system for the intermeshing of the 'respectable' and 'criminal classes' in the workhouse system and particularly in infirmaries. For an overview of Cullen's

voluntary hospitals was most probably influenced by attitudes towards the ‘deserving’ and ‘undeserving poor’.

Irish voluntary hospitals – similar to their British counterparts – were better equipped, better staffed and more prestigious than poor law infirmaries and did not suffer from the ‘taint’ of the poor law. However, by the immediate aftermath of the First World War the voluntary hospital system in general was faced with financial crisis. The long-term tendency of hospital expenditure to grow faster than its traditional sources of charitable income was exacerbated by a short-term post-war funding crisis when subscriptions greatly fell off.⁹⁶ This crisis coincided with increased middle-class demand for hospital provision as technological advances in hospital care undermined traditional domiciliary care by private practitioners. In 1920 the president of the Royal Academy of Medicine in Ireland, R.J. Rowlette, highlighted that the drop in subscriptions had led to a greater reliance on fee-paying patients and limited the number of ‘free beds’ in Dublin hospitals.⁹⁷ In many hospitals the rise was very sudden. In the Meath Hospital in Dublin the income received from fees drastically increased from less than £100 in 1913 to almost £4,000 in 1918.⁹⁸ During 1918 the Adelaide Hospital in Dublin received £589 in patients’ fees. By 1931 this had increased to £6,646.⁹⁹ The emphasis on patients’ fees represented a major shift and voluntary hospitals could no longer be regarded solely as charities for the poor.¹⁰⁰

Patients’ fees were also important to the finances of the Cork voluntary hospitals. Canon Murphy of the South Infirmery informed the Commission of Sick Poor that ‘our funds are entirely inadequate to give free treatment to all who apply’. Admission policies in the hospital ensured that all accident or emergency cases were received. Other patients needed a letter of introduction from a subscriber or from a member of the committee of management to enter and such patients were ‘expected to contribute according to his means’.¹⁰¹ Canon Murphy also believed that the South Infirmery hospital catered for ‘the better working class’. He claimed that the sick in the hospital were ‘not patients such as you would find in the union hospital . . . [and that] a strong sentiment exists among certain classes of the community against going to any hospital to which the taint of the old poor law system is attached’.¹⁰² This is demonstrated in the lack of patients that were fee-paying and from skilled labourer or lower middle-class backgrounds in the Cork District Hospital’s indoor registers. Other anecdotal evidence suggests that many avoided seeking medical attention in the former workhouse. When plans to amalgamate the North and South Infirmaries with the District Hospital were put to Dr Patrick Gould he believed that ‘the people who contribute voluntarily [to hospital care] would object and would not be associated with the poor law system’.¹⁰³ Such an opinion was reported by the Hospital Commission which investigated hospital provision in the early 1930s. The commissioners stated that they were informed locally that plans to establish a municipal hospital in

attitudes towards welfare in the 1860s; see Virginia Crossman, ‘Facts Notorious to the Whole Country: The Political Battle over Irish Poor Law Reform in the 1860s’, *Transactions of the Royal Historical Society (Sixth Series)*, 20, (2010), 162–3; for Cullen’s attitudes towards workhouse infirmaries see Lucey, *op. cit.* (note 12).

⁹⁶ Gorsky, Mohan and Willis, *op. cit.* (note 52), 36.

⁹⁷ R.J. Rowlette, ‘The Problem of the Dublin Voluntary Hospitals’, *The Dublin Journal of Medical Science Including the Transactions of the Royal Academy of Medicine in Ireland, Fourth Series*, 1 (1920), 15.

⁹⁸ <http://www.hospitalsdatabase.lshtm.ac.uk/hospital.php?hosjno=976>, accessed 18 Oct. 2013.

⁹⁹ *Ibid.*

¹⁰⁰ Gorsky, Mohan and Willis, *op. cit.* (note 51), 37.

¹⁰¹ Evidence of Canon Murphy before the CRSDDIP, 1926, *op. cit.* (note 57).

¹⁰² *Ibid.*

¹⁰³ Evidence of Dr Patrick Gould before the CRSDDIP, 1926, *op. cit.* (note 57).

Cork would not be successful because a ‘large proportion of the patients treated in these [voluntary] hospitals were of the artisan and middle-classes who could pay something towards the cost of their treatment, and who would not avail of the facilities afforded by a central hospital’.¹⁰⁴ Evidently long-standing prejudices against the former poor law institution remained and few outside of the city’s poor were willing to utilise this form of health care.

Although accessibility to the city’s infirmaries was eased by ability to pay, nearly half of the patients in the South and North Infirmaries did receive free hospital treatment. This was higher than the national average (39.4%) of free patients in voluntary and semi-voluntary hospitals (see Table 2). The city’s other main general hospital, the voluntary Catholic run Mercy Hospital, had a patient body which was predominately fee-paying. Just over thirteen per cent of patients received completely free treatment in the hospital, indicating differences in the patient social composition between voluntary hospitals. The lack of contributory schemes similar to those in Britain implies that many patients paid fees out of their own pockets. The differing amounts of contributions demonstrated in Table 2 further highlights that some of these patients were made up of middle-class groupings who paid larger fees and skilled labourers who paid in part towards their treatment.¹⁰⁵ The voluntary sector in the city increasingly provided for private paying patients, lower middle-class and skilled labourers.

The issue of accessibility to voluntary hospitals for poor patients did emerge as a political issue in the early 1930s. Criticism of Cork’s voluntary hospitals admission policies came to the fore when an amending bill of the original Public Charitable Hospitals Act of 1930 was introduced into the Dáil (Irish Parliament) in 1932 by the new Fianna Fáil government which was backed by the Labour Party.¹⁰⁶ This legislation provided for the government’s administration of the Irish Hospitals Sweepstakes; an Irish-run international lottery designed to fund Irish hospitals.¹⁰⁷ Allegations were made by a number of TDs that voluntary hospitals failed to provide medical services to the poor. Brooke Brasier, an independent TD for the Cork South-East constituency, claimed there was ‘very considerable difficulty in getting deserving cases into these hospitals’.¹⁰⁸ The Fianna Fáil TD for Cork East, Martin Corry, stated that ‘from enquiries I have made since, I find that these hospitals are refusing to receive poor patients’.¹⁰⁹ The claims were not just related to Cork hospitals. The Parliamentary Secretary for the Department of Local Government and Public Health of the new Fianna Fáil government, Dr Con Ward, stated during the same debate: ‘I find it almost impossible to get a patient into a Dublin hospital at the present unless somebody is going to pay.’¹¹⁰ In relation to Cork, the Hospital Commission, which was established in 1933 to administer the Sweepstakes money, was also critical of the voluntary hospitals in the city stating that they did not provide for the ‘needs of the very poor ... [and] do not appear to cater for the type of patient for

¹⁰⁴ *Report on the Commission of the Relief of the Sick and Destitute Poor*, *op. cit.* (note 1), 30.

¹⁰⁵ At committee of management meetings the ability to pay of individual patients was often discussed, for example see South Infirmary Committee of Management meeting, *The Cork Evening Echo*, 11 December 1928.

¹⁰⁶ For an outline of the political dynamics between the various Irish parties on role of voluntary hospitals and Sweepstakes monies see, Daly, *op. cit.* (note 11), 238–40.

¹⁰⁷ Coleman, *op. cit.* (note 10).

¹⁰⁸ Dáil Éireann Debates, vol. 44, no. 3, 21 October, 1932.

¹⁰⁹ *Ibid.*

¹¹⁰ *Ibid.*

	No payment	10s or less	10s < £2 2s	Over £2 2s
Mercy Hospital (Cork)	302 (13.1%)	46 (0.2%)	1620 (70.1%)	335 (14.5%)
North Charitable Infirmary(Cork)	883 (55.1%)	0	573 (35.7%)	148 (9.2%)
South Charitable Infirmary(Cork)	924 (46.4%)	62 (3.1%)	849 (42.7%)	157 (7.8%)
Irish Free State (Total)	25,016 (39.4%)	6080 (9.5%)	22,068 (34.8%)	10,312 (16.3%)

Table 2: Paying and free patients in Cork and Irish Free State Voluntary and Semi-Voluntary hospitals, 1933. Source: The Hospitals Commission: First General Report, 1933/4 (Dublin: Stationery Office, Saorstát Éireann, 1939), 123–4.

which the union caters'.¹¹¹ The commission also claimed that voluntary 'hospitals do not propose to cater for the very poor'.¹¹² However, the emergence of the Sweepstakes gave the government some influence over the voluntary sector. In return for administering the Sweeps, all participating voluntary hospitals had to provide a quarter of their beds for free.¹¹³

Claims that the non-paying sick were excluded from the voluntary hospital system were, however, exaggerated. Traditionally, and particularly in Cork, general voluntary hospitals provided acute medical care and did not cater for the types of illness that was common amongst patients in public institutions. Of the 140 beds in the Mercy Hospital, seventy-nine were for medical or surgical patients, thirty-seven were gynaecological beds, twenty-four for children and a mere four for isolation patients.¹¹⁴ Similarly the North and South Infirmaries provided beds for acute medical and surgical cases along with children and accident cases. None of the general voluntary hospitals provided for chronic or infectious disease patients. The clinical difference in patients in voluntary and public institutions was demonstrated in the average length of stay in the respective hospitals. 18.9 days was the average stay in the Mercy, 23.8 days in the North Infirmary, and 21.4 days in the South Infirmary; the Cork District Hospital and County Home was 39.4 days.¹¹⁵ Admission to voluntary hospitals was often a clinical as much as a financial decision. This was demonstrated by Canon Murphy of the South Infirmary who believed that 'we have to discriminate on the grounds of the class of case and of the case of illness'.¹¹⁶ Such evidence highlights the fact that voluntary hospitals often did not have the facilities for the type of sickness which was inextricably linked to poverty or old age – infectious disease, chronic and incurable diseases – for which the public rate-aided system catered.

Other developments ensured that the poorest patients and those disadvantaged by distance from urban areas received medical assistance in the better equipped voluntary hospitals. Under the 1862 Act local boards of guardians could pay the medical costs of patients who needed specialised treatment outside the workhouse infirmary. By 1910 a total of 3,631 patients had had their medical costs for non-poor law hospitals met by local boards of guardians although many of these were not sent to hospitals but to institutions for the 'blind, deaf and dumb'.¹¹⁷ This provision was extended under the Free State reforms. Local authorities made arrangements with voluntary hospitals to pay for patients that needed specialised treatment not available in public institutions.¹¹⁸ In Kerry this measure was important because no general or specialist voluntary hospital existed. Regulations were drawn up by the board of public assistance that outlined the procedures involved in sending patients to voluntary hospitals in both Cork and Dublin. Not counting emergency cases, dispensary doctors had to send the patient initially to the county surgeon who then decided whether they needed such specialised treatment.¹¹⁹ By the early 1930s

¹¹¹ *The Hospitals Commission, op. cit.* (note 55), 30.

¹¹² *Ibid.*, 30.

¹¹³ For a recent history of the Sweepstakes, see Coleman, *op. cit.* (note 10).

¹¹⁴ *The Hospitals Commission, op. cit.* (note 55), 126–7.

¹¹⁵ *Ibid.*, 100–1.

¹¹⁶ Evidence of Canon Murphy before the CRSDDIP, 1926, *op. cit.* (note 57).

¹¹⁷ *Annual Report of the Local Government Board for Ireland, being the Thirty-Ninth Report, H.C.*, 1911 [Cd.5847], xxii, 264.

¹¹⁸ Evidence of Dr E.F. Stephenson, *Commission on the Relief of the Destitute Sick and Poor, Including the Insane Poor...Evidence, op. cit.* (note 44), 7.

¹¹⁹ 5 May 1925, KBHPA minute book, KCL, KBH/A/3.

Irish local authorities had paid for the treatment of nearly 11,000 poor patients in voluntary hospitals.¹²⁰

Conclusion

The 1930s brought a new era of hospital development in Ireland. The large sums collected by the Sweepstakes lottery transformed the hospital landscape and led to much badly needed investment in both public and voluntary hospitals which raised the general standard of hospital care. However, it was during the revolutionary period (1919–21) and the early years of the Irish Free State that widespread reform was initiated. This was partly reflective of the new Irish Free State's desire to bestow rights upon its citizens and also resonated with wider international trends in the development of welfare systems. Increasingly attempts were made to remove the principles of deterrence and 'less eligibility' which permeated nineteenth-century welfare regimes, and to establish health care and welfare provisions more acceptable to populations. The Free State's break-up of the New Poor Law and dismantling of the workhouse system was significant and represented the first effort at such reforms in Ireland or Great Britain. Although the potential of reform was limited by the precarious finances of the newly established Irish Free State, significant changes occurred; including the removal of all classes of patients/inmates from the majority of county and district hospitals who were not in need of acute medical care. This reform was particularly successful in County Kerry where the sole focus of all but one of the six institutions under the control of local authorities was the care of the acute sick.

The continued mixing of various classes of patient in the county home and district hospitals remained a significant blight on the system. Such institutions continued to be associated with poverty ensuring that they remained unattractive to those in the skilled labourer and the lower-middle classes. As evidenced in Cork these groups avoided the former workhouse and turned to the extensive voluntary hospital system in the city. These classes increasingly contributed to their health care either as full-paying private patients or subject to means-testing and paying in part. In some of the local authority hospitals, particularly former county infirmaries, similar practices developed. The emergence of fee-payment was rapid and by the 1930s voluntary hospitals had become increasingly reliant on such income, although, unlike the situation in Great Britain, mutualism did not emerge as an important dynamic in Irish health care. The rise in fee-payment was an important development in hospital provision and helped to accentuate the social and medical differences between patients in rate-aided and voluntary hospitals. However, to conclude that a demarcated and two-tiered hospital system emerged – one rate-aided for the poor and one voluntary sector where fee-payment determined access – is somewhat inaccurate. Accusations that the poor were squeezed out from the better equipped hospitals by private and contributing patients were unfounded to some extent. Large numbers did receive free treatment in voluntary hospitals, although the unwillingness of many to enter the former poor law hospitals remained. Furthermore, entry to hospitals was often determined by clinical decisions as much as ability to pay. The voluntary sector's focus on curable acute medical and surgical services left little room for the types of sickness catered for in the 'union' hospitals, which were inextricably linked with poverty such as chronic illness and infirmity. Such patients often became impoverished because of their

¹²⁰ DLGPH, *Annual Report, op. cit.* (note 56), 149.

medical condition. Means-testing of patients in voluntary hospitals did occur but this did not necessarily lead to the poor being denied access to such hospitals. Also, local authorities, aware of the limitations of their own institutions, often paid for poorer patients to receive attention in the better equipped hospitals.