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Pilgrim's Progress: The Landscape of the NHS Hospital, 1948–70

Abstract

This article argues the politics of land-use was fundamental to the challenges of realizing Britain's welfare state. It makes this case through a focus on efforts to plan and design new hospitals in the National Health Service (NHS) between 1948 and 1970. It pays particular attention to the Pilgrim Hospital in Boston, Lincolnshire which serves as an exemplar of a sort of politics that has been largely overlooked due to an overemphasis on central government. At the Pilgrim, a private landowner claimed inadequate consultation had produced a hospital proposal that was counter to local opinion, resulting in their farmstead being preserved within the grounds of a modern tower-on-podium facility. Working back from this aesthetic compromise, the significance of the landscaped hospital is introduced and situated within patterns of NHS land transactions and conflicts over site acquisition. This analysis re-orientates historical research to better reflect the decentralized nature of post-war planning in Britain. It does so by demonstrating how the welfare state internalized the criticisms of wider publics and powerful existing cultural and economic frameworks. These necessary processes formed the real groundwork for state modernization.

Introduction

From the inception of the National Health Service (NHS) in 1948, the politics of land-use served as a major source of delay and progress in hospital development. Mainly private landowners and planners contested different constructions of local opinion that would later be embedded in the

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aesthetics of new buildings.¹ The Pilgrim Hospital, in Boston, Lincolnshire is valuable as a case study of these processes. During the first decade of the NHS, it was one of only three examples (the others being in London and Coventry) where a Compulsory Purchase Order was issued for a hospital site under the 1947 Town and Country Planning Act. Until 1959, the below-market rate of compensation paid by the state for land created a powerful economic motive for opposition. Landowner criticisms, however, should not be dismissed as mere NIMBYism.² Through them, building design was forced to reconcile existing cultural and economic frameworks with highly visual gestures of compromise. This mattered because it contributed to the wider acceptance of expansion in a new public service.

The slow pace of hospital building after 1948 may be out of line with popular assumptions but is well recognized in established histories of the welfare state. Despite a sweeping administrative reorganization and large increases in staffing, this literature has shown that hospital building, and more broadly the expansion of the NHS, was slowed by cross-party austerity policies imposed by the Treasury, combined with declining ministerial power.³ After Aneurin Bevan's resignation as Minister of Health in 1951, current and capital expenditure cuts fell more heavily on healthcare than education or housing as part of a strategy of demand management.⁴ Financial stringency was eased following the 1956 Guillebaud Committee on the cost of the NHS.⁵ For ruling out further economies, the Committee is often credited with spurring a political rapprochement with social and economic planning that eventually made investment programmes, such as the 1962 *Hospital Plan*, possible. Without denying the significance of financial and political battles at the top of government, concentrating upon these points alone risks overstating the degree of central control, and gives a misleading sense of discontinuity to the radical built modernization which did occur from the mid-1960s.

¹ Alex Mold, Peder Clark, Gareth Millward, and Daisy Payling, *Placing the Public in Public Health in Post-War Britain, 1948-2012* (Basingstoke, 2019), 3.

² Katrina Navickas, 'Conflicts of Power: Landscape and Amenity in Debates Over the Rural Super Grid in the 1950s', *Rural History*, 30 (2019), 97.

³ Charles Webster, *The Health Services Since the War Volume I Problems of Health Care: The National Health Service Before 1957* (London, 1988), 204–14; Rodney Lowe, *The Welfare State in Britain since 1945* (Basingstoke, 2005), 190–92; Nicholas Timmins, *The Five Giants: A Biography of the Welfare State* (London, 2001), 203–08; Rudolf Klein, *The New Politics of the NHS: From Creation to Reinvention* (Oxford, 2013), 43; David Edgerton, *The Rise and Fall of the British Nation: A Twentieth Century History* (London, 2019), 302–06.

⁴ Jim Tomlinson, 'Welfare and the Economy: The Economic Impact of The Welfare State, 1945-1951', *Twentieth Century British History*, 6 (1995), 204, 210–11.

⁵ Rodney Lowe, 'Resignation at the Treasury: The Social Services Committee and the Failure to Reform the Welfare State, 1955-57', *Journal of Social Policy*, 18 (1989), 511–13, 522.

Hospital site acquisition was an area not immediately burdened by Treasury parsimony, benefitting from a separate allocation which was especially generous during the early years of the NHS: by 1970 more acreage had been procured for health purposes than agriculture, aviation, transport, or trade and industry.⁶ Despite this remarkable scale of acquisition, transactions frequently ran into conflict. Private landowners' complaints of NHS bureaucracy served as major causes of underspending and building delay. Hospital development was not especially controversial, more at issue was the Ministry of Health's lack of technical staff and expertise, which forced negotiations to be delegated to Regional Boards and architects. The landscaped hospital was a visual strategy to overcome the ensuing conflicts.

Land-use politics demanded modernism be softened by appealing to ideas of belonging, humanization, and historic urbanism. Claiming to embrace the Picturesque qualities of place, architectural rhetoric sought to give the NHS a familiar identity. Recovering the dynamism of social democracy in the 1970s, Guy Ortolano argues that aesthetic paradigms within architectural modernism can be used to make sense of more abstract historical processes.⁷ This article applies Ortolano's approach to the consolidation of the welfare state. It demonstrates how social democratic planning was modified by the market when private landowners inserted themselves into debates about what kind of modernization was natural in their claimed communities.⁸ It reinforces a developing case for seeing publics and culture as significant in altering centralist visions for the NHS.⁹ In doing so, it shows more particularly how concerns about landscape slowed but also guided welfare state realization.

⁶ The National Archives, Public Record Office, Kew [hereafter 'TNA: PRO'], MH 166/877, T.A.D. Sainsbury, 'Government Property Management: A Preliminary Appreciation', 1971, data from Appendix A, Table Analysis of Departmental Land Holdings.

⁷ Guy Ortolano, *Thatcher's Progress: From Social Democracy to Market Liberalism Through an English New Town* (Cambridge, 2019), 124–5.

⁸ Simon Gunn, 'The Rise and Fall of British Urban Modernism: Planning Bradford, circa 1945–1970', *Journal of British Studies*, 49 (2010), 863–4; Alistair Kefford, 'Housing the Citizen-Consumer in Post-war Britain: The Parker-Morris Report, Affluence and the Even Briefer Life of Social Democracy', *Twentieth Century British History*, 29 (2018), 230; Otto Saumarez Smith, *Boom Cities: Architect-Planners and the Politics of Radical Urban Renewal in 1960s Britain* (Oxford, 2019), 16.

⁹ Andrew Seaton, 'Against the "Sacred Cow": NHS Opposition and the Fellowship for Freedom in Medicine, 1948–72', *Twentieth Century British History*, 26 (2015), 426–7; Julian Simpson, *Migrant Architects of the NHS: South Asian Doctors and the Reinvention of British General Practice, 1940s–1980s* (Manchester, 2018), 11–12; Jennifer Crane, "'Save Our NHS": Activism, Information-based Expertise and the "New Times" of the 1980s', *Contemporary British History*, 33 (2018), 52–3; Jack Saunders, 'Emotions, Social Practices and the Changing Composition of Class, Race and Gender in the National Health Service, 1970–79: "Lively Discussion Ensued"', *History Workshop Journal*, 88 (2019), 205–6.

The Landscaped Hospital

Bodfan Gruffydd's 1967 *Landscape Architecture for New Hospitals*, the first and only major post-war text published in Britain on the subject, demonstrates how values such as 'belonging' were associated with whole building form and the accommodation of existing land-use (Fig. 1).¹⁰ How central planning imperatives shaped architectural thought is well historized.¹¹ Immediately after the Second World War, bespoke tower-on-



Figure 1.

Bodfan Gruffydd, *Landscape Architecture for New Hospitals* (London, 1967), 81. Reproduced with permission of the King's Fund. https://archive.kingsfund.org.uk/concern/published_works/000003240?locale=en

¹⁰ Bodfan Gruffydd, *Landscape Architecture for New Hospitals* (London, 1967), 17.

¹¹ W. Paul James and William Tatton-Brown, *Hospitals: Design and Development* (London, 1986), 5, 43; Jonathan Hughes, 'Hospital City', *Architectural History*, 40 (1997), 277–8; John Mohan, *Planning, Markets, Hospitals* (London, 2002), 1202, 154; Peter Blundell Jones, *Architecture and Ritual: How Buildings Shape Society* (London, 2016), 280–2.

podium hospitals predominated, where skyscraper modernity was assumed to improve clinical efficiency and patient throughput.¹² By the mid-1960s, Alistair Fair argues the economic assumptions of the 1962 *Hospital Plan* required more standardized and flexible buildings.¹³ What has not been considered is how external actors also shaped hospital development. Land-use politics forced these commitments by contributing place-based critiques of welfare state expansion; often a building's aesthetics were condemned as too bureaucratic, forbidding, or wasteful for a particular area.¹⁴ Softened modernism can therefore be re-read, justifying a more detailed investigation into the influence of NHS land transactions and conflicts over site acquisition.

This story of the emergence of the landscaped hospital aligns with wider arguments about the way ideas of Englishness and Britishness shaped architectural modernism since before the Second World War.¹⁵ The 1951 Festival of Britain had been seen as symbolizing that style, claiming to unify 'land and people'.¹⁶ Its South Bank exhibits and the Festival Gardens at Battersea Park provided powerful statements of how post-colonial state modernization could be led by new public infrastructure, a vision in which science and technology were mediated by informality, homely settings, and attention to place. Contributors followed the *Architectural Review's* Townscape movement, which called for a revived Picturesque where built forms were arranged to address ideas of historic urbanism and democratic tradition.¹⁷ A renewed attention to aesthetics contributed to Landscape Architecture's status as a professional discipline, with those such as Gruffydd appointed to projects like Harlow new

¹² Jonathan Hughes, 'The "Matchbox on a Muffin": The Design of Hospitals in the Early NHS', *Medical History*, 44 (2000), 30–33.

¹³ Alistair Fair, "'Modernization of Our Hospital System": The National Health Service, the Hospital Plan, and the "Harness" Programme, 1962-77', *Twentieth Century British History*, 29 (2018), 574–5.

¹⁴ Ortolano, *Thatcher's Progress*, 129.

¹⁵ John R. Gold, *The Experience of Modernism: Modern Architects and the Future City, 1928-53* (London, 1997), 169.

¹⁶ Harriet Atkinson, *The Festival of Britain: A Land and Its People* (London, 2012), 49–52.

¹⁷ *Ibid.*, 64–70, 85, 87, 94; Nikolaus Pevsner, *The Englishness of English Art* (London, 1956), 182, cited in William Whyte, 'The Englishness of English Architecture: Modernism and the Making of a National International Style, 1927-1957', *Journal of British Studies*, 48 (2009), 441; Divya Subramanian, 'The Townscape Movement and the Politics of Post-war Urbanism', *Twentieth Century British History* (2020), 5, 10–11.

town.¹⁸ In hospital design, however, a broad range of specialists took up concerns with landscape and Townscape.

Initially, study tours of facilities such as the St Lô Hospital in Normandy, France were relied on to realize new NHS tower-on-podium designs.¹⁹ But such buildings, concentrating almost all medical and ancillary services into vertical tower blocks were soon condemned as too forbidding. The first major multidisciplinary piece of British research, the Nuffield Trust's 1955 *Studies in the Function and Design of Hospitals*, considered humanization measures including the reduction of noise, greater access to sunlight, colour, and creation of open spaces, stating:

Technical considerations should not necessarily be permitted to override those of aesthetic amenity . . . variety in the scale of the buildings should make it easier to bring the hospital into an aesthetically satisfying relation with other buildings in the neighbourhood and with the landscape in general.²⁰

For diminishing vertical scale, Townscape was crucial in softening larger and more technically complex NHS hospitals. The preoccupation with materials, landscaping, and the visual coherence of buildings transcended shifts within modernism, including the decline of the modest Festival of Britain style and ascent of a more monumental Brutalism in the 1960s.²¹

In 1958, Professor Thomas McKeown published the 'Balanced Hospital Community', which appeared to draw upon neighbourhood unit models developed in the Modern Architectural Research Group's 1942 Master Plan for London, later applied extensively to post-war housing estates and new towns.²² McKeown's interpretation of 'balance' meant the greater centralization of acute and chronic services to reflect the single ad-

¹⁸ Alan Powers, 'Landscape in Britain' in Marc Treib (ed.), *The Architecture of Landscape, 1940-1960* (Philadelphia, 2002), 66, 70-72.

¹⁹ For examples see, the Walsgrave Hospital in Coventry designed by D.A. Goldfinch of the Birmingham Regional Board, the Altnagelvin Hospital in Londonderry and Hull Royal Infirmary by architects Yorke Rosenberg & Mardall, and the Queen Elizabeth II Hospital in Welwyn Garden City by C.D. Andrews of the North Western Metropolitan Regional Board; D.A. Goldfinch, 'The Design of Clinics in Great Britain and of Continental Out-Patient Departments', *Perspectives in Public Health*, 76 (1956), 66; Hughes, 'The "Matchbox on a Muffin"', 38, 42-3; Elain Harwood, *Space, Hope, Brutalism: English Architecture 1945-1975* (London, 2015), 284-5.

²⁰ Nuffield Provincial Hospitals Trust, *Studies in the Functions and Design of Hospitals* (Oxford, 1955), 145-7.

²¹ Subramanian, 'Townscape', 14-15.

²² John R. Gold, *The Practice of Modernism: Modern Architects and Urban Transformation, 1954-1972* (London, 2007), 151-5; James Greenhalgh, *Reconstructing Modernity: Space, Power and Governance in Mid-Twentieth Century British Cities* (Manchester, 2017), 121.

ministration of the NHS, with buildings featuring domesticized interiors and village-like landscaping.²³ Nuffield Trust architects John Weeks and Richard Llewelyn-Davies embraced the 'Balanced Hospital Community', claiming their research on new District General Hospitals anticipated growth and change through the organic Townscape of a Cotswold village.²⁴

This drive to humanize hospitals was often related to garnering greater patient and public acceptance.²⁵ The Princess Margaret Hospital in Swindon began to be designed in 1954, with the Nuffield Trust acting as consultants to the architects Powell & Moya.²⁶ A tower-on-podium was retained, but the three-hundred and sixteen bed main ward block was just four-stories tall. Surrounding the tower, extensive use was made of low-rise buildings for diagnostic and treatment services. As construction reached completion in 1964, what gained the most popular attention were details appealing to the building's surroundings. The Penguin Special *What's Wrong with Hospitals?* praised its hilltop location and: 'random stone [that] repeats the skewbald homeliness of Wiltshire without resorting to sham rustic.'²⁷ Architectural critic Diana Rowntree thought the use of double-glazed windows in areas such as the Operating Theatre brought the natural environment into the hospital:

What Powell & Moya have done is to combine three elements – the individual requiring help, the technology that can give it to him, and a beautiful piece of country . . . The traditional hospital could be frightening because science predominated. The doctors were proud of their gear and saw no reason to conceal it . . . At Swindon, science is presented to the patient in the way he can most happily accept it.²⁸

A similar partnership between the Nuffield Trust and Powell & Moya produced different results at Wexham Park Hospital in Slough, which began to be designed in 1958. It further diverged from the tower-on-podium, with the only multi-storey structure being an administrative building at the centre of the hospital. Wards accommodating a total of two-

²³ Thomas McKeown, 'Fundamental Problems in Hospital Planning', *British Medical Journal*, 1 (1959), 122–4.

²⁴ Richard Llewelyn-Davies, 'Architectural Problems of New Hospitals', *British Medical Journal*, 1 (1960), 769, 772.

²⁵ Victoria Bates, 'Humanizing' Healthcare Environments: Architecture, Art and Design in Modern Hospitals', *Design for Health*, 2 (2018), 10.

²⁶ Powell & Moya often preferred to do their own landscaping rather than employ specialists; Elain Harwood, 'Post-War Landscape and Public Housing', *Garden History*, 28 (2000), 113.

²⁷ Gerda L. Cohen, *What's Wrong with Hospitals?* (London, 1968), 118.

²⁸ *Guardian*, 26 February 1960, 9.

hundred and eighty-five beds were configured in sixteen-bed Nuffield Bays, referred to as 'bungalow'-style, and were separated by garden courtyards.²⁹ A press release issued in January 1962 by Windsor Group Hospital Management Committee read:

The hospital site will resemble that of a country village, with trees, large open lawns and an ornamental lake – all set in the grounds of a late Victorian mansion now demolished. Nothing less like the clumsy, fussy, dark-windowed, redbrick, multi-storeyed hospitals of the 19th-century tradition could be imagined.³⁰

In design, NHS planners found that claiming to work within local arrangements and with landscape continuity provided a defence against critics. In 1966, the architect Philip Powell even described Wexham's layout as 'anti-functional' for concealing the true extent of the hospital and creating the sense of a small town.³¹ Other responses reveal a disjuncture between such architectural judgements and public attitudes. In the case of the Princess Margaret Hospital, some patients thought the hospital hotel-like whilst others complained of noisy wards and of a lack of privacy due to the extensive use of glass.³² At Wexham, responses provide better insight as to why considerations of site mattered: letters to the editor in the *Daily Telegraph* describing low-rise wards as wasteful when compared to American designs and the multistory administrative tower as symbolic of NHS bureaucracy.³³ The Windsor Hospital Management Committee defended Wexham's location, giving a press statement recounting its history as a purchase of voluntary subscribers and the former landowner's record as a hospital patron. References were again made to the preservation of parkland, with the Management Committee arguing alternative uses, such as housing or industry, would have been much less sympathetic to the surroundings.³⁴ Early exchanges like these are significant because they indicate we should not approach the landscaped hospital as simply a product of debate within architectural or planning thought.

Appeals to place were modified by experiences of site acquisition. The Pilgrim Hospital in Boston evidences how private landowner opposition could even undermine the aesthetic value architects attached to

²⁹ Berkshire Record Office [hereafter 'BRO'], D/H6/21/3/1, Windsor Group Hospital Management Committee, *Wexham Park Hospital, Slough: Work to Begin Soon*, 1–5.

³⁰ BRO, D/H6/21/3/11, Windsor Group Hospital Management Committee, 'Slough's Garden City Hospital: Realisation of 25-year-old Dream', 1 January 1962.

³¹ Phillip Powell, 'Architect's Approach to Architecture', *RIBA Journal*, March 1966, cited in Peter Stone (ed.), *British Hospital and Healthcare Buildings: Designs and Appraisals* (London, 1980), 16–8.

³² Harwood, *Space, Hope, Brutalism*, 294–5; *Guardian*, 31 January 1961, 5.

³³ BRO, D/H6/21/3/7, *Daily Telegraph*, n.d; BRO, D/H/6/21/3/9, *Daily Telegraph*, 8 January 1962.

³⁴ BRO, D/H6/21/3/14, *Slough Advertiser*, n.d.

humanized design. Although the Ministry of Health was beginning to assert minimum standards from 1957 in the form of *Hospital Building Notes*, it still lacked leadership and expertise before the 1959 appointment of Chief Architect William Tatton-Brown.³⁵ In the interim, it relied on private architectural firms to produce new ideas by holding a design competition for the Pilgrim.³⁶ Building Design Partnership's winning entry was a mainly horizontal building of four-hundred and seventy-four beds that used an L-shaped layout. Two spinal corridors served the wards, and a single multi-storey tower was placed at the centre for administration and consultants' accommodation. As required by Holland County Council's planning permission, East Skirbeck House had been preserved. However, in the entry's design concept this detail was presented as a deliberate act of landscaping, with the stated aim being to produce a domestic and reassuring atmosphere in-keeping with the rural surroundings.³⁷ The competition judge, S.E.T. Cusdin was disappointed with the combination of a low-rise hospital and the farmstead.³⁸ It produced an overly compact site filled by a building incapable of expansion.³⁹ Cusdin also thought Building Design Partnership's entry too similar to the Wexham Park Hospital, and demanded the design be revised to incorporate a taller multi-storey tower to make more economical use of the space.⁴⁰ This significantly delayed overall progress. Even with the guarantee of long-term construction finance under the 1962 *Hospital Plan*, the Pilgrim's redesign would not be completed until 1966. Cusdin later reflected that in such situations, the use of compulsory purchase for land was 'too wrapped up in politics' to be effective.⁴¹ Here, the need to minimize further interference with existing land-use outweighed any potential criticisms of NHS bureaucracy that might be inferred from a larger tower-on-podium form.

The persistence of external criticism partly explains why landscaping eventually became less central to the presentation of new NHS hospitals. This is not to say that efforts to soften buildings ended. In fact,

³⁵ Hughes, 'The "Matchbox on a Muffin"', 33.

³⁶ TNA: PRO, MH 88/273, Letter from E.A. Arnold to V.R. Duberry, 27 June 1958.

³⁷ *Builder*, 14 April 1961, 689–701.

³⁸ The Royal Institute of British Architects selected S.E.T. Cusdin as the competition judge who had worked for the architectural firm Easton and Robertson later the designers of the tower-on-podium Addenbrooke's Hospital in Cambridge, see; C.A. Short, K.J. Lomas, R. Giridharan, A.J. Fair, 'Building Resilience to Overheating into 1960's UK hospital Buildings Within the Constraint of the National Carbon Reduction Target: Adaptive Strategies', *Building and Environment*, 55 (2012), 74.

³⁹ TNA: PRO, MH 88/274, Letter from R.N. Whiston to L.J. Thomas, 7 December 1957; TNA: PRO, MH 88/274, Note by H. Henry, 17 November 1961; later Derek Lovejoy and Associates were consulted about the Pilgrim's landscaping but no archival record indicates this significantly altered the design.

⁴⁰ *Architect and Building News*, 26 April 1961, 542–5.

⁴¹ S.E.T. Cusdin, 'The Design of Modern Hospitals' *Journal of the Royal Society of Arts*, 114 (1966), 920.

publications from 1967 such as Gruffydd's *Landscape Architecture for New Hospitals* and the World Health Organization's first monograph on hospital planning continued to celebrate the application of Townscape.⁴² Within the Ministry of Health, however, there was increasing dissatisfaction with the time and expense taken to realize new hospital buildings. By the mid-1960s, a cross-party concern to increase the pace of reconstruction had begun to override the previous acceptance of bespoke and decentralized approaches in favour of standardized designs.⁴³ Concepts of traffic and obsolescence were more important in Llewelyn-Davies and Weeks' 1962 design for Northwick Park Hospital in Harrow. Such a changing emphasis may have been influenced by the rising tide of criticism from residents and academics that challenged the neighbourhood unit's ability to create functioning communities.⁴⁴ Northwick Park instead scaled up the prefabricated and modular aspects of the 1955 Vale of Leven Hospital in Alexandria to the whole concept of an 'indeterminate building'.⁴⁵ New hospitals located on highly urbanized or existing NHS sites continued to employ a deeper tower-on-podium, such as Ralph Tubbs' 1967 cruciform design for the Charing Cross Hospital at Fulham.⁴⁶ Working back from the above instances of aesthetic compromise further clarifies the role of land-use politics in shaping NHS expansion.

The Politics of Land-use

The politics of land-use was fundamental in determining the cost, pace, and form of reconstruction.⁴⁷ The Second World War brought a series of related reports on reform including from the Barlow Commission, Uthwatt Committee, and Scott Committee. They investigated the negative effects of property speculation, the dispersal of London's population, and the protection of agriculture to preserve an idealized aesthetic of the landscape and increase food production.⁴⁸ When these recommendations were collected in the 1944 White Paper on Town and Country Planning,

⁴² Gruffydd, *Landscape*, 11; H.M.C Macaulay and Richard Llewelyn-Davies, *Hospital Planning and Administration* (Geneva, 1966), 67–77, 81–2, 85–6.

⁴³ Fair, "Modernization of Our Hospital System", 561.

⁴⁴ Greenhalgh, *Reconstructing Modernity*, 138–9; Ortolano, *Thatcher's Progress*, 150–4.

⁴⁵ Jonathan Hughes, 'The Indeterminate Building', in Jonathan Hughes and Simon Sadler (eds) *Non-Plan: Essays on Freedom, Participation and Change in Modern Architecture and Urbanism* (London, 2000), 90; the Vale of Leven was designed by Joseph Gleave for the Western Regional Board, Fair, "Modernization of Our Hospital System", 556–8.

⁴⁶ For other examples see, Wycombe General Hospital in High Wycombe and Greenwich District Hospital in London, Blundell-Jones, *Architecture and Ritual*, 282; Hughes, 'Hospital City', 271; Stone, *British Hospital*, 34, 61.

⁴⁷ Michael Tichelar, *The Failure of Land Reform in Twentieth-Century England: The Triumph of Private Property* (London, 2018), 23, 88–90, 150–1.

⁴⁸ David Matless, *Landscape and Englishness*, (London, 2016), 283, 298–9.

they amounted to a rejection of land nationalization in favour of a mixed economy; usage was to be state regulated without common ownership.⁴⁹ The 1947 Town and Country Planning Act gave the NHS powerful development rights including compulsory purchase for fixed 1948 values, otherwise known as 'existing use' compensation. After 1945, both Labour and Conservative governments continued to defend portions of the Act that aided their manifesto commitments to house building targets and city centre reconstruction.⁵⁰ The Conservatives did, however, abolish charges on price increases derived from planning permission or 'betterment' in 1953 and 'existing use' compensation in 1959. For social democratic planning, this meant the alternative values of the market would have to be contended with, and its powers to influence NHS land policy were gradually increased.⁵¹

Patterns of early Ministry of Health land transactions help us to understand this dynamic. They show major expansion whilst demonstrating the moderating effects of the mixed economy. Whereas prior to 1956 restraint was seen in NHS capital expenditure, spending on land was great and exceeded one and a half million pounds per annum for the years 1950, 1952, and 1954.⁵² Not all this expenditure went towards new hospital development; large transfers of property were made from authorities such as the War Office for facilities like the Queen Alexandra Military Hospital in Cosham. Significant underspending was also recorded between 1949 and 1953, with a total of thirteen million pounds in grants unfulfilled by approximately thirty-five per cent.⁵³ Attempting to defend existing budgets to the Treasury, the Ministry attributed purchase delay to the frequency with which private landowners disputed 'existing use' compensation.⁵⁴ The problem was only aggravated by the later rise in land's market value.⁵⁵ The result was a reduction in acquisition estimates between 1955 and 1962 that would prevent expenditure exceeding one million pounds per annum.⁵⁶ The Ministry was also increasingly

⁴⁹ Glen O'Hara, *Governing Post-War Britain: The Paradoxes of Progress, 1951–1973* (Basingstoke, 2012), 132–3.

⁵⁰ John Davis, 'Macmillan's Martyr: The Pilgrim Case, the 'Land Grab' and the Tory Housing Drive, 1951–9', *Planning Perspectives*, 23 (2008), 131–2; Otto Saumarez Smith, 'Central Government and Town-Centre Redevelopment in Britain, 1959–1966' *The Historical Journal*, 58 (2015), 220.

⁵¹ Kefford, 'Housing the Citizen-Consumer', 230.

⁵² Webster, *Health Care in the National Health Service Before 1957*, 209; Tomlinson, 'Welfare and the Economy', 204, 210–211; Lowe, 'Resignation at the Treasury', 511–13, 522.

⁵³ TNA: PRO, MH 77/230, Regional Hospital Boards: Estimates, (May 1948–December 1953).

⁵⁴ TNA: PRO, MH 77/231, S.H. Findlay, Appropriation Account 1950–51, 15 January 1953.

⁵⁵ O'Hara, *Governing Post-war Britain*, 136.

⁵⁶ TNA:PRO, MH 166/853, 'Expenditure in the Acquisition and Receipts from the Sale of Land and Buildings in England and Wales – Extracted from Civil Appropriation Accounts', n.d.

pressured by the Treasury to sell off any surplus property.⁵⁷ This fed into ideas of modernization by forcing hospital obsolescence to be more clearly defined.

When the Minister of Health, Iain Macleod, called for 'speedy action' to secure the first hospital building programme in 1955, attempts were also made to accelerate land disposals. The first properties that Regional Boards were encouraged to sell were ornamental gardens and farms, originally attached to asylums and infectious disease hospitals for income, therapeutic, and isolation purposes.⁵⁸ A 1954 Ministry circular deemed this land 'unnecessary hospital equipment', a point elaborated upon by its Parliamentary Secretary Richard Thompson, who in response to critics, claimed mechanization now made farm labour untherapeutic.⁵⁹ Deinstitutionalization was advanced through the 1957 Percy Commission, the 1959 Mental Health Act, the 1962 *Hospital Plan*, and a 1966 Treasury circular.⁶⁰ A bargain of new hospitals for old was made explicit by the later Minister of Health, Enoch Powell. His 1961 'Water Towers' speech justified in aesthetic terms the necessity to dispose of institutions with: 'built-in tendencies to perpetuate the old'.⁶¹ Similar derisions of the past can be seen in the Conservatives' other modernization proposals of the time that claimed a business-like approach, including the 1963 Beeching Report on railway closures.⁶² Hospital disposals were also encouraged under Harold Wilson's Labour government after 1964, with the per annum value of sales continuing to increase.

Outside of hospital closures, clear articulations of early NHS land policy were remarkably rare.⁶³ This may have been because, in order to avoid scrutiny, the Ministry of Health had quickly developed arguments about the distinctive value of NHS property. Central control over hospital land remained limited throughout the period with responsibility delegated to Regional Boards. For instance, after 1948, no survey or valuation of the assets inherited by the health service was ever undertaken. The Ministry's estimates from this time also demonstrate that fully offsetting the opening of new hospitals with closures of existing facilities was never

⁵⁷ Not a trend seen across Britain, Vicky Long, ' "Heading Up a Blind Alley"? Scottish Psychiatric Hospitals in the Era of Deinstitutionalization', *History of Psychiatry*, 28 (2016), 117–8.

⁵⁸ Julie Collins, *The Architecture and Landscape of Health: A Historical Perspective on Therapeutic Places, 1790–1940* (London, 2020), 170–4, 214–29.

⁵⁹ *Parliamentary Debates* (Commons), 599, 11 February 1959, 1321.

⁶⁰ TNA:PRO MH 123/506, 'Hospital Lands and Buildings: Transactions in Land for Hospital Purposes: Consolidation of RHB Memoranda for Circular HM (55) 72'; TNA:PRO, MH 166/853, TC 1/66 'Disposal of Surplus Land by Government Departments, 14 February 1966.

⁶¹ Tony Cutler, 'Economic Liberal or Arch Planner? Enoch Powell and the Political Economy of the Hospital Plan', *Contemporary British History*, 25 (2011), 472–3.

⁶² Saumarez Smith, *Boom Cities*, 16, 40.

⁶³ Crane, "'Save Our NHS'", 54–7.

really an intention; sales only made up a quarter of the total value of transactions between 1958 and 1970.⁶⁴ Furthermore, unlike acquisitions, estimates for disposals were often exceeded, indicating the transaction process was not itself a limiting factor.⁶⁵ After the 1968 Fulton Report on reforming the civil service, the Treasury's newly formed Business Team argued that a lack of central oversight and the slow progress of closures meant hospital land should be transferred to an independent expert body.⁶⁶ Successfully rejecting the involvement of property specialists, the Ministry's Assistant Secretary Raymond Gedling made the case that 'to talk of market value' and expertise was 'meaningless' because of the special purpose of social services.⁶⁷ Records of highly decentralized land transaction suggest the formation of this status occurred largely outside of central government. It is worth, then, considering how Regional Boards persuaded private landowners to accept a view of hospital modernization that was so often in tension with the market.

Conflicts Over Site Acquisition

Public passivity is often mentioned as a factor allowing the deferment of early NHS hospital building.⁶⁸ Analyses of polling data by Tony Cutler, Glen O'Hara, and Nick Hayes find competing concerns for the improvement of housing and conservative attitudes towards change in treatment experience assuaged reconstruction demands.⁶⁹ In planning, outside of highly visual exhibitions, mechanisms of formal consultation were seemingly lacking prior to the late 1960s.⁷⁰ Nevertheless, external actors could

⁶⁴ TNA:PRO, MH 166/853, 'Expenditure in the Acquisition and Receipts from the Sale of Land and Buildings in England and Wales – Extracted from Civil Appropriation Accounts', n.d.

⁶⁵ TNA:PRO, MH 166/853, Letter from Nick Jordan Moss to J.P. Carswell, 'Hospital Closures', 14 August 1968.

⁶⁶ Rodney Lowe, *The Official History of the British Civil Service: Reforming the Civil Service, Volume I: the Fulton Years, 1966–81* (London, 2011), 173–5.

⁶⁷ TNA:PRO, MH 166/877, Raymond Gedling to Mr Phillip, 'Sainsbury – Government Property Management', 5 November 1971; Mohan, *Planning, Markets, Hospitals*, 94–97; only later did the private sector become a major buyer of disposed NHS property, John Mohan, 'Geographical Aspects of Private Hospital Development in Britain', *Area*, 16 (1984), 191–2, 197.

⁶⁸ Lowe, *Welfare State*, 105–09; Charles Webster, *The National Health Service: A Political History* (Oxford, 2001), 25, 35, 60; Klein, *New Politics*, 57.

⁶⁹ Tony Cutler, 'A Double Irony? The Politics of National Health Service Expenditure in the 1950s', in Martin Gorsky and Sally Sheard eds, *Financing Medicine: The British Experience Since 1750* (London, 2006), 342–6; Glen O'Hara, *From Dreams to Disillusionment: Economic and Social Planning in 1960s Britain* (Basingstoke, 2007), 169–70, 205; Nick Hayes, 'Did We Really Want a National Health Service? Hospitals, Patients and Public Opinions before 1948', *English Historical Review*, 26 (2012), 641–5.

⁷⁰ Peter Shapely, 'Planning, Housing and Participation in Britain, 1968–1976', *Planning Perspectives*, 26 (2011), 77–9; Alex Mold, *Making the Patient-Consumer: Patient Organisations and Health Consumerism in Britain* (Manchester, 2015), 4–5; Alex Mold, 'Exhibiting Good Health: Public Health Exhibitions in London, 1948–71' *Medical History*, 62 (2018), 9.

still make themselves heard by claiming to represent local opinion. More recent literature has problematized the idea of a homogenous public opinion in favour of recognizing distinct publics. Terms of condescension including NIMBYism have also been rejected in favour of acknowledging active agents.⁷¹ By taking anti-NHS and anti-hospital closure activism seriously, Andrew Seaton and Jennifer Crane demonstrate how the ideological and emotive meanings of the health service were immediately contested and affected policy.⁷² Conflicts over site acquisition forced Regional Boards to construct a persuasive case for hospital modernization. Therefore, rather than reading building delay as indicative of passivity, we might instead see evidence of active deliberation.

The visual amenity of a prominent new hospital site was often thought important enough to challenge competing land-uses. Modernist campus-like designs in North America and Europe seemed to define a need for large green field spaces.⁷³ The 1943 Scott Report, however, had also given agricultural and preservationist interests a special claim to such land, reaffirmed by the subsidies and protections of the 1947 Agriculture Act and 1949 National Parks and Countryside Act.⁷⁴ The Scottish Department of Health operated its own budgets and nation-specific legislation but led Britain in terms of planning.⁷⁵ In Dundee, the Agricultural Executive Committee opposed Eastern Regional Board's attempts to purchase the Invergowrie Estate in 1952, condemning the poor accessibility of an out of town hospital. Others including the Secretary of State for Scotland, Hector McNeil, considered a semi-rural site with the better access to sunlight, reduced traffic noise, and an uninterrupted prospect across the River Tay: 'important for convalescence'.⁷⁶ More technical rationales for siting were limited by a lack of research on the subject until the mid-1960s.⁷⁷ Although landscape's therapeutic properties had been seemingly called

⁷¹ Selina Todd, 'Phoenix Rising: Working-Class Life and Urban Reconstruction, c. 1945–1967', *Journal of British Studies*, 54 (2015), 689–93; Mold et al., *Placing the Public*, 33–4, 91–2; Navickas, 'Conflicts of Power', 97.

⁷² Seaton, 'Against the "Sacred Cow"', 426–7; Crane, "'Save Our NHS'", 54–7.

⁷³ Julie Willis, Philip Goad, and Cameron Logan, *Architecture and the Modern Hospital: Nosokomeion to Hygeia* (London, 2019), 191, 195, 202–3.

⁷⁴ Gordon E. Cherry and Alan Rogers, *Rural Change and Planning: England and Wales in the Twentieth Century* (London, 2018), 154–7, 209–11.

⁷⁵ John Stewart, 'The National Health Service in Scotland, 1947–74: Scottish or British?', *Historical Research*, 76 (2003), 393.

⁷⁶ *Dundee Courier*, 7 January 1952; National Records of Scotland [hereafter 'NRS'], NRS, HH 101/499, 'Note for the Secretary of State on Representations Made to Him on 1 December 1953, Invergowrie Estate, Dundee'.

⁷⁷ Peter Cowan, 'Hospitals in Towns: Location and Siting', *Architectural Review*, 137 (1965), 417–21; TNA: PRO, MH 166/1293, A.J. Anstey, 'Hospital Size Study', 7 May 1973.

into question in NHS property disposals, early decisions about acquisition continued to find value in attractive surroundings.⁷⁸

Why the NHS attempted to negotiate competing interests over sooner deploying statutory powers deserves further attention. The Ministry of Health's 1948 *Transactions in Land for Hospital Purposes* circular placed few restrictions on the employment of compulsory purchase. Soon after the war, schemes for city centre reconstruction, housing, and transport and energy infrastructure, all made extensive use of zoning and the below market-value purchases that Compulsory Purchase Orders enabled.⁷⁹ Considering the Ministry of Health reported compensation disputes as the main cause of underspending on land, it is surprising to note just three Orders had been issued during the first decade of the NHS. If not for lack of finance, hesitancy to deploy these powers may have been due to an absence of expertise. The housing-drive, supported by both the Labour government of Clement Attlee and subsequent Conservative administrations, saw cabinet status, technical staff, and resources spun off from the Ministry of Health into a dedicated Ministry of Housing and Local Government in 1951.⁸⁰ This might explain why NHS land policy and the *Transactions* circular laid down few rules and instead relied on an existing base of experience amongst Regional Boards.⁸¹ A reluctance to apply compulsory purchase may have also been linked to fears of increasing public dissatisfaction with state controls.⁸²

Two scandals over land-use planning served to elevate these concerns. In 1954, a Parliamentary investigation found civil servants to be prejudiced against returning the requisitioned the Crichel Down Estate after its use as a wartime bombing range ended.⁸³ Later that year, Edward Pilgrim took his own life on a half-acre of land earmarked for council housing; an 'existing use' value Compulsory Purchase Order of sixty five pounds had been issued for land he mortgaged in 1950 at a market value of five-hundred and fifty pounds.⁸⁴ Both cases bolstered a tabloid narrative calling for the abolition of compulsory purchase, where property-owning individuals were positioned as victims of inhumane state bureaucracy. However, Conservative governments including that of Winston

⁷⁸ Collins, *Landscape of Health*, 11–2; a pattern also seen in the selection of sites for the University of York and Harlow new town, Harwood, *Space, Hope, Brutalism*, 258–9; Harwood, 'Post-War Landscape', 104.

⁷⁹ Greenhalgh, *Reconstructing Modernity*, 82–3.

⁸⁰ Named the Ministry of Local Government and Planning between January and October 1951; Catherine Flinn, *Rebuilding Britain's Blitzed Cities: Hopeful Dreams, Stark Realities* (London, 2019), 43.

⁸¹ TNA: PRO, MH 77/230, 'Preliminary Note: Transactions in Land for Hospital purposes', 9 August 1948.

⁸² Ina Zweiniger-Bargielowska, *Austerity in Britain, Rationing, Controls and Consumption, 1939–1955* (Oxford, 2000), 60–9.

⁸³ J.A.G. Griffith 'The Crichel Down Affair' *The Modern Law Review*, 18 (1955), 557–8.

⁸⁴ Davis, 'Macmillan's Martyr', 125–6.

Churchill were eager to retain statutory powers to support the housing-drive. Thereafter, reforms instead concentrated on planning permission charges and landowner compensation.⁸⁵ In 1955, during the first NHS use of compulsory purchase for land adjacent to the Royal National Orthopedic Hospital in Great Portland Street, London, the Treasury stressed Orders should be used only as a last resort lest they produce a 'nasty jam of the Crichele Down variety'.⁸⁶ The *Transactions in Land for Hospital Purposes* booklet, republished in 1956, appears to have responded by making conditions for land acquisition more stringent.⁸⁷ Scandal made the application of Orders controversial, meaning they would be reserved only for the most intense cases of opposition.

The second use of compulsory purchase by the NHS occurred in Coventry. The Walsgrave Hall Estate was selected as a new hospital site due to its attractiveness and large open space.⁸⁸ In 1953, the land had been zoned for housing, and the owner, W.V. Scott proceeded to divide the park into plots for a two-hundred and eighty home neighbourhood unit.⁸⁹ Scott appealed against the proposed hospital stating her 'modernized village' offered more amenities to nearby residents than a building which serviced an entire region. Other landowners agreed, arguing rezoning would amount to: 'the Development Plan becoming just another weapon in the armory of local authorities in their already one-sided warfare against private owners of the land'.⁹⁰ The Birmingham Regional Board won the appeal by exhibiting a model of a fourteen-storey tower-on-podium hospital, emphasizing the benefits patients would feel from a view across the parkland and River Stowe.⁹¹ The NHS acquired the land in 1959. Yet, it is also clear that Scott's comments resonated with those in the immediate area of Walsgrave, who continued to meet to demand assurances from the Board that the new building be aesthetically 'gentle' and not of asylum type appearance.⁹²

In comparison to the above cases, opposition in Boston was exceptional because it came from a single individual with powerful political influence. Impressed by its pastureland and mansion, the Sheffield Regional Board requested East Skirbeck House be zoned for hospital purposes in 1953.⁹³ Soon after, the owner Alderman Thomas Henry Richardson succeeded in

⁸⁵ O'Hara, *Governing Post-War Britain*, 104.

⁸⁶ TNA: PRO, T 227/506, Letter from R.L. Workman to Mr Clarke, 18 June 1955.

⁸⁷ TNA: PRO, MH 123/506, 'Hospital Lands and Buildings: Transactions in land for hospital purposes: consolidation of RHB memoranda for Circular HM (55) 72'.

⁸⁸ Birmingham Archives [hereafter 'BA'], MS 1523/22/1, 'A Meeting of the Coventry Hospital Working Party', 8 July 1953.

⁸⁹ BA, MS 1523/22/1, 'A Meeting of the Coventry Hospital Working Party', 13 July 1954.

⁹⁰ *Coventry Evening Telegraph*, 30 October 1956.

⁹¹ *Coventry Evening Telegraph*, 10 May 1957.

⁹² *Coventry Evening Telegraph*, 5 November 1959.

⁹³ TNA: PRO, MH 88/273, Sir Basil Gibson to Michael Reed, 20 September 1954.

persuading the Holland County Council to rescind this planning permission.⁹⁴ New hospital support was well established in Boston, dating back to a voluntary proposal in 1934, given regional priority by the Ministry of Health's 1945 *Hospital Survey*, and energized by a 1952 Management Committee press conference declaring a 'hospital fight' for recognition.⁹⁵ Even so, Richardson was able to build a strong case for opposition. He alluded to the case of Edward Pilgrim by claiming farming was vital to his 'interest in life', complained the value of his estate had been 'frozen' by zoning, and added that learning of the proposal from a 'gossiping charwoman' insulted his standing as a County Councillor.⁹⁶ The Ministry was remarkably sympathetic to these concerns. Nevertheless, they called on Richardson's 'public spirit' with assurances that the proposal came from 'local people' and not 'someone in London'.⁹⁷ Indeed, the National Liberal Member of Parliament for Holland with Boston, Sir Herbert Butcher, made efforts to persuade Richardson to sell.⁹⁸ On the other hand, Richardson may have found support from the local branch of the National Liberals, who performed well in local authority elections by using the Crichel Down Affair in campaigns against state controls.⁹⁹ Although a Compulsory Purchase Order was issued, in 1959 Richardson succeeded in securing a favourable purchase by agreement, with the guarantee that his farmstead would not be demolished. Events in Boston matter because they demonstrate the politics of land-use could have an extraordinary influence upon the progress of hospital development.

Clearly, private landowners such as Alderman Thomas Henry Richardson may have used exaggerated images of bureaucracy endangering individual freedom in order to obtain compensation closer to market value. But this politics went beyond self-interest. It also had the potential to mobilize broader public concern over the lack of consultation in planning. This was less frequently the kind of large-scale resistance and organized opposition shown by preservationist groups and shopkeepers against proposals for new city centres, housing, transport and energy infrastructure.¹⁰⁰ However, unlike the bodies responsible for those schemes, the Ministry of Health was uncommonly lacking in technical staff and expertise. This is what made new hospital proposals especially vulnerable

⁹⁴ TNA: PRO, MH 88/273, Letter from L.C. Marris to the Ministry of Health, 23 October 1953.

⁹⁵ *Lincolnshire Standard and Boston Guardian*, 3 May 1947, 8.

⁹⁶ TNA: PRO, MH 88/273, L.R. Macbeth to Michael Reed, 8 May 1954.

⁹⁷ *Ibid.*

⁹⁸ TNA: PRO, MH 88/273, Note from John Vaughan-Morgan, 23 March 1957.

⁹⁹ *Lincolnshire Standard and Boston Guardian*, 21 May 1955, 13; I.F. Nicholson, *The Mystery of Crichel Down* (Oxford, 1986), 200; Mark Egan, 'The Grass-roots Organisation of the Liberal Party, 1945-1964', PhD thesis, University of Oxford, 2000, 23-4, 244, 253.

¹⁰⁰ Todd, 'Phoenix Rising', 689-90; Greenhalgh, *Reconstructing Modernity*, 85, 140-4, 170; Saumarez Smith, *Boom Cities*, 82-7; Navickas, 'Conflicts of Power', 98-9.

to increasing levels of dissatisfaction with state controls. Constructions of local opinion had to be negotiated if building progress was to be made. The accommodation of external criticism had a longer-term aesthetic legacy. The design of new NHS hospitals was forced to be more sensitive to issues of place.

Conclusion

In September 1970, Roger Park from Building Design Partnership (BDP)'s Graphics Unit visited the site of the partially completed Pilgrim Hospital to produce a series of promotional photographs. Members of the project team had instructed the Unit to capture completed interiors as well as the use of concrete and aluminium, variations of space and light, and any completed garden courtyards.¹⁰¹ Earlier in 1968, Boston Hospital Management Committee had sent BDP a pamphlet featuring the completed hospital drawings. It opened with a short description of the preservation of East Skirbeck House, now used as the Committees' headquarters, and how efforts would be made to supplement the landscape in the development of a new hospital environment.¹⁰² Perhaps influenced by this description, the majority of images captured by Park featured new buildings juxtaposed with the farmstead or overlooked by its garden's mature copper beech and walnut trees. The firm's project manager, William White, wrote in the *Guardian* that this focus on environment was not an afterthought but integral to the Pilgrim Hospital as a: 'social organism, giving it identity through a sense of place'.¹⁰³

This article has set out to understand how such a view of the landscaped hospital came to the fore. In doing so, it further demonstrates how publics and culture were as fundamental to the challenges of consolidating Britain's welfare state as financial and political battles at the top of government. Despite an extended period of Treasury austerity, resource for hospital site acquisition was generous. Labour and Conservative governments of the period supported legislation which enabled the reconstruction of city centres, housing, and transport and energy infrastructure, causing both to remain muted on conflicts created by the mixed economy of land. A lack of central direction stemmed from the Ministry of Health's absence of technical staff and expertise. Regional Boards and architects were therefore encouraged to plan and design independently of central government and in advance of finances for construction becoming available. Even though disputes over market value and individual property

¹⁰¹ Document bundle provided to the author by Building Design Partnership, Memorandum from Bill Finch to Roger Park, 22 May 1970.

¹⁰² Boston Group Hospital Management Committee, *Pilgrim Hospital: Boston, Lincolnshire* (Boston, 1968), 4.

¹⁰³ *Guardian*, 18 April 1973, 19.

rights largely went beyond the politics of central government, they should not be dismissed as mere NIMBYism.¹⁰⁴ When private landowners challenged the lack of consultation in planning, they began to problematize state expansion in a way which clearly resonated with wider publics.¹⁰⁵ Re-reading softened modernism as a response to conflicts over site acquisition, we begin to see how the welfare state was undergoing a dynamic kind of realization from its earliest decades.

Since the late 1990s, the healing power of outdoor space, gardens, and courtyards has been extensively reappraised with the aim of improving individual experiences of healthcare.¹⁰⁶ In the post-war period landscape mattered. Appeals to place aimed to reconcile technically complex public infrastructure with the politics of land-use. Instances of aesthetic compromise, like the farmstead within Pilgrim Hospital, evidence how external criticism and powerful existing cultural and economic frameworks were internalized by the welfare state to give new services like the NHS a familiar identity. These necessary processes formed the real groundwork for state modernization.

¹⁰⁴ Navickas, 'Conflicts of Power', 97.

¹⁰⁵ Mold, et al., *Placing the Public*, 33–4, 91–2.

¹⁰⁶ Clare Cooper Marcus and Marni Barnes, *Healing Gardens: Therapeutic Benefits and Design Recommendations* (Chichester, 1999), 15–7.