

DON'T LOOK BACK? VOLUNTARY AND CHARITABLE FINANCE OF HOSPITALS IN BRITAIN, PAST AND PRESENT

John Mohan and Martin Gorsky



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Despite these attempts to diffuse blame, responsibility for what follows rests with us.

John Mohan
Martin Gorsky
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A note on sources

Apart from the database on which our quantitative analyses rely, we have drawn extensively on archival investigations. The sources for these are indicated in the footnotes. For those not familiar with referencing conventions, we give details of the archive followed by class numbers which aid location of cited materials. The most commonly used abbreviations for archives here are the Public Record Office (indicated by 'PRO'), and the Scottish Record Office ('SRO'); otherwise we name the archive in question (e.g. Tyne and Wear Archives Service). Classmarks vary from one archive to another.

We have also given full citations to Parliamentary debates, following the usual conventions.

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SUMMARY

This book provides a reassessment of the role of charitable and voluntary fundraising for health care, with a particular focus on the hospital. It does so firstly by summarising the principal findings of a major research project on the pre-National Health Service (NHS) voluntary hospitals. Independent of the state and funded initially by charitable gifts, these hospitals cared for the acute sick before 1948 and were the centres of research and teaching. We discuss their performance, and that of the voluntary system, in its last decades. Secondly we explore contemporary trends in charitable fundraising, examining its extent and impact. The key elements of the book are the following:

1. A review of proposals for a greater role for the voluntary sector in the provision of welfare services. Discussion of this issue has emanated from several positions on the political spectrum, and ranges from a desire to roll back the frontiers of the state, to a concern to revive participation in the institutions of civil society.
2. A reassessment of the record of voluntary hospital provision before the NHS, and of the role of charity since 1948. The findings are organised around four central themes:
 - *Charitable finance*: Although the inter-war years were a time of expansion, this was also the period in which the funding of voluntary hospitals was transformed. Traditional philanthropy proved insufficient and gave way to private payment and a shift to mass contributory arrangements. However, the late 1930s saw financial crisis looming, as current account deficits multiplied and the asset base of many institutions was eroded. The revival of charity in the 1990s has posed a rather different problem: the unpredictability of charitable finance (rather than its inadequacy, since charity is not being relied upon to provide core services).
 - *Provision and utilisation*: The spontaneous and localist aspects of voluntary action led to the uneven development of

hospital provision. The result was that well before the 'postcode rationing' identified with the NHS access to care was inequitable, since it was shaped by residence. Under the NHS it has been large urban hospitals, particularly those with a glamorous national and international reputation, that have attracted the bulk of charitable funds. The tendency for charity to enhance regional variations and hence inequities has therefore persisted. The pattern of charitable endowments and income remains dominated by a very limited number of institutions, mainly located in London.

- *Co-ordination and planning:* Improvements in the quality and availability of hospital care depended on collaboration and partnership, both with the public sector and with other voluntary institutions. However, the traditional independence of the voluntary hospitals impeded this process and despite some promising initiatives in particular localities there was still no co-ordinated hospital system by 1939. In recent years the revival of charitable giving has proven to be inimical to planning. The local enthusiasms underpinning voluntary support for individual institutions can conflict with proposals to rationalise provision in order to achieve wider regional or national strategic objectives.

- *Democracy and participation:* Openness, subscriber democracy and accountability were attributes of the voluntary hospital from its inception, though participation was initially limited to wealthy middle-class contributors. The transition to mass contribution in the early 20th century strengthened popular support for the institutions, though leadership remained in the hands of traditional elites. There are some parallels here with the situation under the NHS. Although community support of health services is widely encouraged, NHS services are largely run by organisations

which have little direct input from those who make considerable commitments to raise money for their local facilities.

3. A concluding assessment of the extent to which the issues posed by the uneven development of charity remain with us today, as a consequence of the recent expansion of charitable fundraising. The parallels are not exact but are nonetheless instructive. We end with a review of some potential policy options for striking a balance between charitable provision and social need.

1 INTRODUCTION

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‘The grievous 20th century error of the fundamentalist left was the belief that the state could replace civil society and thereby advance freedom a key challenge of progressive politics is to use the state as an enabling force, protecting effective communities and voluntary organisations’¹.

With statements such as these, Prime Minister Tony Blair has sought to differentiate ‘New’ from ‘Old’ Labour, clearly indicating that, in terms of support for voluntary activity, the ‘Third Way’ will be very different from its predecessors. The Prime Minister has not been alone in extolling the potential contribution of non-profit organisations to modern welfare delivery. Our intention here is to use both historical and contemporary evidence to examine the role of charitable finance and voluntary action in one of the core services of the British welfare state: the provision of hospital treatment.

There are several reasons why these issues are of interest at the present time. Firstly, there has been a steady expansion in charitable fundraising by, or on behalf of, NHS authorities. Medical charities have always been recipients of substantial income but a novel feature of the past two decades (in contrast to the first 30 years of the NHS) has been the growth of charitable appeals to supplement the NHS’s resources. We examine these trends in more detail below (Chapter 4) but the following examples are illustrative:

- high-profile fundraising campaigns for individual hospitals, the most prominent being the ‘Wishing Well’ appeal for the Great Ormond Street Hospital for Sick Children, in London;

1 T. Blair, *The Third Way*, Fabian Society pamphlet, 1998, cited in J.Kendall, *The mainstreaming of the third sector into public policy in England: whys and wherefores*, London School of Economics, Civil Society Working Papers, 2 (London, 2000), p.17.

- efforts to return some hospitals to the control of the voluntary sector;
- an increase in major appeals launched by health authorities, from around 12 per annum in the late 1970s to about 50 per annum in the late 1980s²;
- an expansion in the value of assets held by NHS charitable funds from £247 million in 1982-3 to £1.07 billion in 1997-8 (figures refer to England);
- growth in income from NHS charitable funds from £57 million in 1982-3 to £298 million in 1997-8 and £315 million in 1998-9.

The sums involved may appear small against NHS total expenditure of over £40 billion. However, this average figure conceals important variations between health authorities and individual hospitals. We show that, for some NHS Trusts (as NHS hospitals are now referred to), charitable income is equivalent to as much as 20% of their revenue budget.

This work is also topical because of the emphasis in Labour's policies on the new Primary Care Groups (PCGs) and Primary Care Trusts (PCTs) in England and Local Health Groups (LHGs) in Wales. Just as the Conservatives' 1991 reforms of the hospital service created NHS Trusts to give hospitals greater scope for local initiative, so these new entities have the flexibility, if they wish, to develop partnerships with the voluntary sector. One element of this may well be the transfer of services to voluntary organisations and/or an expansion of local fundraising and voluntary initiative. Some examples given below indicate the direction of possible developments (for example, the retention of small hospitals as charitable bodies). The likely pattern of local fundraising, if mirroring that of hospital endowments, will be very uneven.

2 M. Lattimer and K. Holly, *Charity and NHS reform* (London, 1992).

Aside from these developments, there is a renewed interest (from both academics and politicians) in voluntarism and charity in general, because of the perceived failings of state welfare and also because of the potential role of voluntary organisations in promoting social integration. Against this general background, several quite specific proposals have been made for greater charitable involvement in health care delivery, and part of our purpose is to evaluate these arguments critically. These arguments should be seen against the background of theoretical discussions about the role and potential benefits to society of voluntarism and non-profit organisations, and these are outlined in Chapter 2.

The core of the book consists of two main sections. In Chapter 3 we summarise the principal findings of a research project which has created the most comprehensive database currently available on the pre-NHS voluntary hospital system. We focus on four key features of this system: the financial stability and viability of the hospitals; the degree of equity in service provision and utilisation; the extent to which hospitals were accountable to their communities; and the problems of planning a comprehensive service that arose from what was essentially a competitive and individualistic system. Focussing on these four themes allows re-evaluation of the performance of the voluntary hospital in its final decades and permits parallels to be drawn with contemporary dilemmas. Presentation of novel data – for example on hospital utilisation by area of residence – and the production of data at constant prices for consistent sets of hospitals, means that our project sheds new light on the question of the strengths and weaknesses of the pre-NHS system.

Moving beyond 1948, in Chapter 4 we first discuss the persistence of charitable involvement in the finance and delivery of health care: some charitable organisations continued in existence but reoriented their activities, while other elements of charity

were absorbed into the NHS. We then concentrate on the post-1979 expansion of charity, where, mirroring our historical discussion, we consider themes of equity, financial stability, accountability and planning. Empirically we emphasise the growing significance of charitable income to the NHS, the blurred boundaries between charitable and statutory provision of services, and the planning deficit posed by major charitable appeals.

In our concluding section we draw together around our four main themes the common threads from our historical and contemporary analyses, and consider ways in which policy might address the uneven distribution of charitable resources. This is important because we think there is evidence that disparities in the availability of such funds are widening, and because the purpose of charitable fundraising largely remains that of new buildings and equipment for high-profile causes.

The scope of voluntary and charitable activity is potentially vast and we acknowledge two key areas of interest which we have not considered. These are: the role of the non-profit sector in service delivery, and the role of voluntary labour in health and social care. The first includes many areas of activity in which the traditional strengths of voluntarism have been amply displayed, such as the hospice movement, community care, or the treatment of people with AIDS. This field also includes other organisations which may appear less likely candidates for charitable status, such as some large private hospital chains, whose services are not available on a charitable basis and who do not rely on charitable sources of funds to any great extent. There are, therefore, questions to be raised about the degree to which all this can be regarded as charitable activity³.

The second area mentioned relates to the extent of volunteer support in health and social care. There is a huge range of vol-

3 I. Williams, *The alms trade* (London, 1989).

1 INTRODUCTION

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untary activity which contributes to the overall aims of the health and social services. Full consideration of this would be well beyond the scope of this paper, but a very useful recent review has been provided by the Institute for Volunteering Research⁴, while the National Association of Hospital and Community Friends also documents the work done by its members⁵. Instead of addressing these aspects our preference is for a tighter focus on financial issues because of the important historical parallels that are raised by the revival of charity in health care.

⁴ Institute for Volunteering Research, *Volunteering in the NHS: report of a survey*, available online at <http://www.ivr.org.uk/nhs.htm>.

⁵ The Association is at Fairfax House, Causton Road, Colchester, Essex CO1 1RJ. In addition to the voluntary work done, it is estimated that the Leagues of Friends raise some £24 million annually for equipment, buildings and environmental improvements to health facilities. There is consequently some overlap with the activities considered in the present paper.

2 THE REVIVAL OF VOLUNTARISM: THEORETICAL PERSPECTIVES

The context for the empirical investigation which follows is the current concern, in both political theory and policy analysis, to explore the potential for the voluntary provision of welfare services. Equally fashionable is the enthusiasm for the revival of ‘civil society’, in which voluntarism can play a leading role⁶. What do these terms signify? William Beveridge, the architect of the British welfare state, once defined voluntary action as: ‘...private action, not under the directions of any authority wielding the power of the State,... outside each citizen’s home...’ and aimed at ‘...improving the condition of life for him and his fellows’⁷. The term ‘civil society’ also denotes a sphere of activity distinct from that of the state and the market, in which private individuals convene to address matters of general concern. The conviction that a strong civil society, bound together by networks of voluntary associations, is an essential ingredient of a healthy democracy dates back at least to the writings of de Tocqueville in the 1830s⁸. However it is the present dissatisfaction with the operation of state welfare which largely underpins the current interest. In this chapter we will explore various proposals, emanating from a range of political viewpoints, to return elements of welfare provision to the voluntary sector. We preface these accounts with a review of theoretical arguments which highlight the strengths of voluntary provision.

6 For example, in 1999 the London School of Economics inaugurated its Centre for Civil Society, while in 2000 the free market think-tank, the Institute of Economic Affairs, reorganised its Health and Welfare Unit as ‘Civitas’, the Institute for the Study of Civil Society.

7 W. Beveridge, *Voluntary action: a report on methods of social advance* (London, 1948), p. 8.

8 A. de Tocqueville, *Democracy in America* (edn. London, 1988, ed. J. P. Mayer, trans. G. Lawrence), Volume Two, Part II, chs. 5, 7; E. Meehan, *Civil society* (Swindon, 1995); J. Keane, *Democracy and civil society* (London, 1988).

2.1 The virtues of voluntarism

Social scientists working on the non-profit sector have suggested several reasons for the existence of voluntary institutions in modern economies. On the one hand voluntarism is interpreted as a response to market failure⁹. In circumstances of imperfect knowledge on the part of the consumer, particularly in cases of asymmetric information, such as the provision of health care, the absence of the profit motive is important in convincing consumers of the trustworthiness of those on whom they are relying. Likewise, non-profit status helps convince donors that their funds will be properly accounted for¹⁰. Voluntarism also emerges in circumstances of 'state failure', when governing institutions are unable to mobilise consent for the provision of a particular good, either because of resentment of additional taxation, or perhaps because of disapproval of the service itself. Birth control services in inter-war Britain or AIDS charities today offer good illustrations of provision pioneered by the voluntary sector at times when state agencies were reluctant to become involved.

Moving away from these somewhat negative arguments, others contend that voluntarism has its own positive qualities¹¹. The history of welfare services usually shows that, other than in exceptional circumstances, voluntary groups have led the way in identifying new areas of need or in developing fresh strategies to cope with emerging problems. This applies as much to health

9 B. Weisbrod, 'Towards a theory of the voluntary nonprofit sector in a three sector economy', in E. S. Phelps (ed.), *Altruism, morality and economic theory* (New York, 1975).

10 H. Hansmann, 'The role of nonprofit enterprise', *Yale Law Journal* 89 (1980), pp. 835-901.

11 L. Salamon, *Partners in public service: government-nonprofit relations in the modern welfare state* (London, 1995).

and unemployment insurance in the 19th century as it does to mental health or community care services in more recent decades. An honourable record of innovation cannot be dismissed simply as a response to state or market failure.

Furthermore, voluntarists can mobilise local feeling for a cause. Before the NHS, hospital fundraisers were adept at persuading donors to contribute to 'their' hospital, emphasising the place of the institution in the life of the community, and its contribution to the local economy, for example by effecting the rapid return of the workforce to employment, or by reducing the need for state support (and thus taxation). The ability to bring disparate social interests together in a common cause, cutting across economic and social divisions, provides another important justification for voluntary social action. A fourth and related contribution is the capacity of voluntarism to promote public debate on a given social issue, with the potential to shape policy accordingly¹².

Finally, it is important to note that the voluntary sector should not be seen as something which has developed entirely independently of the state. Instead, historians would now generally emphasise a more nuanced perspective, which acknowledges that the voluntary sector and the state have existed in a close, if not symbiotic, relationship¹³. Most fundamentally, the parameters within which the voluntary sector operates are set by the legal framework for the receipt and administration of charitable gifts. The activities of the state may also circumscribe or

12 R. Wuthnow, 'The voluntary sector: legacy of the past, hope for the future?' in L. Salamon (ed.), *The voluntary sector in comparative perspective* (Princeton, 1991), pp. 22-25.

13 T. Skocpol et al., 'How Americans became civic', in T. Skocpol and M. P. Fiorina (eds.), *Civic engagement in American democracy* (Brookings Institution Press, 1999), pp. 27-80; G. Finlayson, *Citizen, state and social welfare* (Oxford, 1994).

expand the scope for voluntarism, or may blur the boundaries between the voluntary and statutory sectors. Much of the debate is therefore about how and where these boundaries should be drawn; most contemporary controversies about the scope of voluntary effort are of this type.

These somewhat abstract arguments have been drawn on, explicitly or implicitly, by numerous authors, either to argue for the strengthening of civil society in general, or for the return of welfare to the voluntary sector in particular.

2.2 The revival of civil society and charity

Recent decades have witnessed renewed interest in the concept of civil society, an autonomous sphere, apart from both market and state, in which voluntary association can flourish. There are several reasons for this. Firstly, there have been attacks on the bureaucratic, centralised welfare state from various points on the political spectrum. From the right, state provision is viewed as stifling community initiative and removing choice. There has also been an argument that the absence of mechanisms for involvement in service delivery heightens the risk of abuse (excessive consumption) of services, especially when they are free at the point of use. The absence of the price mechanism from the core services of the welfare state has been a key theme in such arguments¹⁴. From the left, bureaucratic modes of service delivery are seen as depersonalised and unresponsive. Both left and right would agree, furthermore, that the balance of power between the interests of producers and users of services has swung too far in favour of the former. Related to all this is the argument that the welfare state is engulfed by a chronic

14 A. Seldon, 'Preface' in A. Seldon et al., *Re-privatising welfare: after the last century* (London, 1996), pp. x-xv.

fiscal crisis, in which the state cannot simultaneously reconcile the competing imperatives of supporting economic growth and maintaining social harmony through satisfying public expectations¹⁵. Against this background and given the likelihood of tax revolts among the electorate, there is a search for innovative, lower-cost methods of service delivery to relieve the burden on the state.

More generally, voluntarism is advocated as a means of reviving participation in community affairs and political institutions, through its capacity to generate 'social capital' (a term denoting the bonds of friendship, mutuality and trust which undergird civic engagement in healthy democracies). The end of the Cold War lent a new piquancy to these ideas, which were much discussed in the transition to democracy in Eastern Europe. There the vacuum left by the collapse of the state was attributed to the absence of strong networks of intermediate institutions. Another key influence is the work of Robert Putnam, a political scientist who claims to have established empirical evidence for the role of social capital in creating the good society. Focusing first on the uneven rates of development in northern and southern Italy, Putnam argued that the country's most successful regions, in economic and political terms, were those possessing high levels of social capital: dense interpersonal networks, born out of active involvement in voluntary, associational activity¹⁶. Reversing conventional causal priorities, he suggested that by cultivating such activities complex civic networks actually fostered and preceded (rather than followed from) economic success, because (among other things) they promoted trust and information exchange. His recent work traces the decline of

15 J. O'Connor, *The fiscal crisis of the state* (New York, 1973).

16 R. D. Putnam, et al., *Making democracy work: civic traditions in modern Italy* (New York, 1993).

associations in American civic and social life, a trend which he believes augurs ill for the future of democracy in the United States¹⁷.

Putnam's theme has been picked up in several ways. Labour's Commission on Social Justice laid heavy emphasis on the concept of social capital, arguing that 'communities do not become strong because they are rich they become rich because they are strong'¹⁸. Academics studying important social outcomes, such as health inequalities, have defended the view that social capital can play a role, over and above material factors, in explaining variations in health standards between places¹⁹. More generally, voluntary association is also seen as central to rebuilding a sense of community and citizenship, and addressing the 'moral crisis' of the welfare state through restoring the balance between rights and responsibilities²⁰. Indeed, the philosophy of the so-called 'Third Way' implicitly presumes a redrawing of the boundary between state and civil society²¹. In a succession of speeches, Prime Minister Tony Blair and Chancellor of the Exchequer Gordon Brown have emphasised the responsibilities incumbent on individuals to give something back to their communities, either in terms of time or money. This is seen positively, as a project of civic renewal, in which, albeit on a small scale, everyone can 'make a difference'. New

17 R. D. Putnam, *Bowling alone: the collapse and revival of American community* (New York, 2000).

18 Commission on Social Justice, *Social justice: strategies for national renewal* (London, 1994).

19 R. Wilkinson, *Unhealthy societies: the afflictions of inequality* (London, 1996).

20 D. Selbourne, *The principle of duty: an essay on the foundations of the civic order* (London, 1994); Finlayson, *op. cit.*

21 A. Giddens, *The Third Way: the renewal of social democracy* (Cambridge, 1998), pp.78-85.

Labour thinking, at least as informed by the DEMOS think-tank, has also stressed the importance of charity as an outlet for innate ethical impulses – ‘reciprocal altruism’ – which motivate social citizenship and duty to others²². Legislative steps are therefore being taken to promote charitable donations and voluntarism²³.

There are many positive aspects to this but there are also potential difficulties. It might be argued that contentions as to the value of social capital and voluntarism are most often put forward by social elites for whom repairing communities from the bottom up will not increase the burden of taxation. The promotion of voluntarism could thus be seen as a strategy of costless redistribution. There are also questions as to how and where the boundary between public and private responsibility is to be drawn. For example, Labour’s New Opportunities Fund, though launched at a time of steady growth in NHS resources, received criticism because of the belief that it might be used to substitute, at least in part, for publicly-provided services²⁴. Another important debate in the contemporary NHS concerns the differential access of communities to charitable resources. The emphasis in contemporary social policy on partnerships and matched funding may give an advantage to places with ready access to such funds. While recent growth in charitable

22 G. Mulgan and C. Landry, *The other invisible hand: remaking charity for the 21st century* (London, 1995), pp.14-21.

23 Kendall, *op. cit.*, pp.22-3.

24 Further information on the New Opportunities Fund can be found at www.nof.org.uk. Its initiatives in the health area have largely involved grants to establish ‘Healthy Living Centres’. These are set up through partnerships between statutory and voluntary agencies, and are aimed at promoting healthier behaviour and lifestyles. Grants made by the NOF are not, therefore, intended to be used to supplement or to replace statutory funds, but rather are to establish new initiatives, which can then be picked up by a mixture of statutory and private funding.

and voluntary activity may be welcome then, it is not necessarily without problems; indeed, as we suggest, it may reproduce some of the weaknesses of the pre-NHS system. We now examine more specific arguments for a greater role of charity in health care.

2.3 Voluntarism in health care

Commentators from several points on the political spectrum have at various times called for a revival of voluntarism in the hospital sector. In this section we summarise some key arguments and then turn to the historical evidence used in their support.

The characteristic claim of New Right commentators such as David Green and Arthur Seldon is that nationalisation of the hospitals stifled a huge wave of charitable effort which, if left unchecked, would have provided a comprehensive service (with private and local authority services covering those not eligible for charitable care). Thus, according to Seldon, the NHS 'prevented the development of more spontaneous, organic, local, voluntary and sensitive services [that would have] better reflected consumer preferences'²⁵. Green suggests that while we cannot know with certainty what would have happened had the hospitals not been nationalised, we can draw reasonable inferences from the rate and nature of change in hospital provision up to 1948²⁶. He clearly wishes us to infer that the level of provision was expanding steadily, leading to the development of a more comprehensive service responsive to the needs of users. In

25 A. Seldon, *The litmus papers: a national health dis-service* (London, 1980), p. 5.

26 D. Green, *Reinventing civil society: the rediscovery of welfare without politics* (London, 1993), p. 21.

a more dramatic version of this claim Arthur Seldon suggests that the state simply ‘mounted the already-galloping horse’ of voluntarism²⁷.

Central to this argument is a conception of the role of voluntarism in promoting community control and participation²⁸. Green sees voluntary activity as a means of reinventing forms of collective social action which do not have a political dimension. Voluntary institutions are essential to a pluralist democracy since they help secure the dispersal of power. Participation in voluntary institutions is an essential pre-requisite for fostering civic virtues, rather than simply relying on ‘socialist materialism’²⁹. Furthermore, voluntary institutions are seen as innately more responsive to need and consumerist demands, than an ‘overstuffed, underperforming state’³⁰. Green argues that individual choice is the best way to secure welfare, since ‘individuals – and not governments – know best how to regulate their own affairs’³¹. The lesson of history, he contends, is surely that ‘political caring is a poor substitute for the mutual caring of civil society’. He goes so far as to argue that, to the extent that good health care is provided in the NHS, it is because the ethos of voluntary service has not been entirely extinguished³².

The case from the right therefore has the following main elements. Firstly, state intervention was built on a vibrant tide of localist, community-based initiatives, which if left alone would have produced a comprehensive service. Those who defend

27 A. Seldon, *Capitalism* (Oxford, 1990), p. 250.

28 R. Bellah et al., *Habits of the heart: individualism and commitment in American life* (New York, 1995); R. Putnam et al., *Making democracy work* (1993).

29 D. Green, *Community without politics* (London, 1996), p. 130.

30 R. Whelan, *The corrosion of charity*, p. 18.

31 D. Green, *Community without politics*, vii, 15.

32 *Ibid*, pp. 143-4.

state welfare purely out of fear – on the grounds that the alternative to state welfare is no welfare – are therefore misguided³³. Secondly, there is a moral argument in favour of self-help, which is always preferable to state intervention, with its ‘forcible transfer of resources from the wealthy (and not-so-wealthy) to an ungrateful population of dependants’³⁴. Thirdly, voluntarism is much more responsive to community needs and preferences than a bureaucratic state monopoly. Finally, in the act of providing for those needs and responding to those preferences, greater participation is engendered: ‘active citizenship’ promotes trust and, perhaps, the formation of social capital.

Other commentators endorse the virtues of voluntarism without proposing a wholesale return to it. Welfare pluralists, for example, argue that the Keynesian welfare state is too bureaucratized, centralised and impersonal. It was an appropriate response to straitened circumstances and a more homogeneous society in the post-war years, when it ostensibly ‘seemed a lesser evil compared with a return to the alleged bad old days of the Poor Law and inter-war service’³⁵. It is not appropriate to a more heterogeneous society in which consumers are less willing to be grateful recipients of standardised services. Greater pluralism is therefore held to be responsive to need and to empower citizens. Thus, Nick Bosanquet contends, there is a case for ‘managed pluralism’ as a means of ‘promoting access to services and patient choice’. However, pluralism can degenerate into what Wistow terms a ‘naïve anti-statism’³⁶. Bosanquet

33 R. Whelan, *Corrosion of charity*, p. 1.

34 C. Pierson, *Beyond the welfare state* (Cambridge, 1991), p. 201.

35 N. Bosanquet, *A successful NHS: from aspiration to delivery* (London, 1999), p. 8.

36 G. Wistow, ‘Offloading responsibilities for care’, in R. Maxwell (ed.), *Reshaping the NHS* (Oxford, 1988).

draws lessons from three sectors on the boundary between health and social care: services for those with learning difficulties; long-term care for the elderly; and home care services. He attributes the success of pluralism to cost (lower staffing costs), flexibility and specialisation, and believes that the same advantages could accrue in the acute hospital sector. This could be achieved if Primary Care Groups (PCGs) were given freedom to enter into service agreements with a range of agencies, which would stimulate growth of local providers. He suggests that the NHS would do better if it 'did less and encouraged substantial new sources of funding and service supply'³⁷. What he does not do is develop some of the implications of his model in terms of equity, democracy and accountability. To whom would these new 'sources of service supply' be accountable, and what would happen if they withdrew from serving a particular area?

Other left-of-centre commentators propose a revived voluntarism as part of a project of democratic renewal. Taking as his point of departure the Private Finance Initiative (PFI), Chris Ham contends that one possible corollary of this development is that the NHS could become a 'virtual organisation': with buildings in private ownership and an increasing number of staff employed outside the NHS, 'a network of relationships and agencies will increasingly replace hierarchical bureaucracy'³⁸. He therefore argues that there is scope for a range of alternative forms of service ownership and delivery to emerge. The prospect of non-profit forms of organisation has attractions, he suggests, compared to the potential for control of hospitals by commercial organisations under the PFI. Equally, however, the difficulty of rebuilding the voluntary tradition ought not to be

37 N. Bosanquet, *op. cit.*, p. 28.

38 C. Ham, *Public, private or community: what next for the NHS?* (London, 1996), p. 46.

underestimated. Ham acknowledges difficulties in coordination in the pre-NHS era but does not comment on the adequacy of voluntarism, though he believes that it is easy to exaggerate the weaknesses of that system³⁹. His main conclusion, however, does not depend on his evaluation of the historical record: instead, he contends that the key issue is finding more flexible, responsive and participatory approaches to service delivery irrespective of ownership.

In this respect his proposals closely follow those of Paul Hirst, who complains that arguments about the merits of the public and private sectors is irrelevant and sterile: both have strengths and weaknesses; at root, however, the problem is one of large-scale, inflexible, unresponsive organisation. Hirst questions ‘whether some fusion is not possible between the voluntary and decentralised approach, which lost out to state welfare, and the conception of comprehensive, well-funded public services, which the national state appeared to provide and which localism and mutual aid could not?’⁴⁰.

Hirst therefore argues for what he terms an associational welfare state; here he is drawing on the neglected tradition of guild socialism. Firstly, a citizen’s income would be guaranteed to all, irrespective of their degree of participation in the labour market. Secondly, tax funding would be relied on to promote equity, accompanied by strong government regulation. Thirdly, citizens would contract with local purchasing organisations for particular packages of services. Hirst (and Ham) propose the devolution of public welfare and other services to voluntary self-governing associations, who would be empowered to obtain public funds to provide services to their members. Citizens would join

39 *Ibid.*, pp. 45-6.

40 P. Hirst, *Associative democracy: new forms of economic and social governance* (Cambridge, 1994), pp. 6-7.

an organisation (such as a health care purchasing cooperative) which best reflected their preferred choice of services. They would have the right, once a year, to decide whether to remain with their chosen organisation or move to another one. The suggestion is that citizens would use their power, individually or collectively, to hold professionals and providers accountable, and to stimulate greater responsiveness and innovation. For example, co-religionists could band together to provide culturally sensitive services. Another central issue is control. Hirst argues against public ownership on the grounds that 'the time has come to question the state, the better to promote welfare'⁴¹. Greater pluralism would, he believes, promote responsiveness and efficiency while retaining the redistributive objectives of the welfare state.

A forceful argument in favour of these proposals relates to their potential for promoting democratic invigoration and social integration. This would be achieved by binding all members of a community together around a particular service. At a time of growing use of private services⁴² there are concerns about the residualisation of public welfare, with services increasingly being seen as being provided for a shrinking, dispossessed minority. As growing numbers exit the public sector entirely, Hirst contends that they will become more reluctant to shoulder the tax burden necessary to pay for it⁴³. Associational welfare might be one way of preventing this 'secession of the successful' into a private domain⁴⁴. In addition to a tax-financed basic package, individuals could purchase higher-quality or

41 P. Hirst, *Associative democracy*, p. 167.

42 T. Burchardt, J. Hills and C. Propper, *Private welfare and public policy* (York, 1998).

43 P. Hirst, 'Associationalist welfare: a reply to Marc Stears', *Economy and Society* (1999), 28(4), 590-97.

44 C. Lasch, *The revolt of the elites* (New York, 1995); R. Reich, *The work of nations* (New York, 1991).

extra services but these would be provided by those same organisations delivering collective services. In this way the ability of welfare services to bridge social divides and promote social integration would be retained.

Various objections have been levelled at the notion of a non-profit, associationalist purchasing authority for welfare⁴⁵. Firstly, it may be idealistic to assume that individuals are always best placed to determine how to meet their health needs. The result may be under-consumption, leading to the postponement of treatment to the point at which it becomes excessively costly⁴⁶. Another pitfall is the risk of inequality. If individuals are to choose between different service providers, there will inevitably be variations in the quality of services on offer, while the readiness of associationalists to accept a plurality of funding sources (donations, local taxation, or the levying of charges) would also tend to inequality⁴⁷. Even if public funds were allocated on need-based criteria this funding mix might perpetuate, rather than resolve, problems of postcode rationing.

Hirst principally deals with the organisation of the purchasing of health care. What of the organisations involved in service delivery in his proposed system? New forms of ownership of services might be required. Pollard et al. advocate the development of a British equivalent of the French 'économie sociale'⁴⁸, creating organisations which are neither public nor private but which 'trade in the market for a social purpose'. They support their case by reference to the growth of the independent health sector which includes 'a wide range of charitable and religious

45 M. Stears, 'Needs, welfare and the limits of associationalism', *Economy and Society* (1999), 28(4), 570-89.

46 *Ibid.*, pp.577-8.

47 *Ibid.*, p. 586; Hirst (1999), *op. cit.*, pp. 594-5.

48 S. Pollard, T. Liddle and B. Thompson, *Towards a more cooperative society* (London, 1994), p. 15.

(and, yes, commercial) providers who instead of undermining public health, actively contribute to its promotion'. This is a somewhat exaggerated argument since critics correctly point to the exclusive character of non-profit hospitals in Britain, some of which have long departed from their original charitable objectives⁴⁹. If publicly run health services were transferred to such non-profit organisations, a crucial issue would be the terms on which they were funded and on which they competed for funds. In other states, non-profits have been subject to vigorous competitive pressures as a result of market-led reform of public health care systems and pro-competition legislation⁵⁰.

A further practical point to raise is whether an appropriate organisation could be devised which would make hospitals more accountable to their communities. It is true that there are strong ties between hospitals and their localities but these are usually evident only when there are proposals to close them, which generate resistance. Otherwise public involvement in hospital affairs is very limited. But how would participation be promoted, beyond a small group of committed individuals? If this were the case, would such bodies be any more democratic than existing health authorities? Given the scale and complexity of most hospitals, the proposal to return them to genuine community ownership and control is a daunting one, though

49 I. Williams, *The alms trade* (London, 1989); B. Griffith, S. Iliffe and G. Rayner, *Banking on sickness: commercial medicine in Britain and the USA* (London, 1987).

50 For discussion of these developments see, inter alia: J. Needleman, 'Nonprofit to for-profit conversions by hospitals, health insurers, and health plans', *Public Health Reports* (1999), 114(2), 108-119; G. Josephson, 'Private hospital care for profit? A reappraisal', *Health Care Management Review* (1997), 22(3), 64-73; E. Norton and D. Staiger, 'How hospital ownership affects access to care for the uninsured', *RAND Journal of Economics* (1994), 25(1), 171-185; F. Sloan, 'Commercialism in nonprofit hospitals', *Journal of Policy Analysis and Management* (1998), 17, 234-52.

there have been a limited number of cases in which small facilities of a 'community hospital' character have been transferred out of the NHS (see Chapter 4).

There is then a series of intriguing, and contentious, proposals for the reintroduction of voluntary participation into the hospital service, their aim being to promote the elements of consumer choice and active citizenship which public provision can stifle. In much of what follows our rationale is to inform these debates with a clearer view of the way in which voluntary hospitals operated before the NHS.

2.4 Lessons of history?

It is striking that the 'associationalist' literature makes little reference to historical precedent, beyond rather general allusions to the high level of voluntary activity in Britain before the welfare state⁵¹. The exception to this is the work of Green and Seldon, who ground their ideas firmly in welfare history⁵². Their claims for the vigour of voluntary hospital finance before nationalisation rely largely on two sources: Robert Pinker's compilation of English hospital statistics and a 1937 report by Political and Economic Planning (PEP)⁵³. Pinker presented a snapshot of data for several years at different points in time (1861, 1891, 1911, 1921 and 1938) which gave a broad picture of aggregate trends. These fully captured the growth in bed provision and the rise in levels of income. However, the reporting units used, London, Scotland, and the rest of England and Wales, allowed

51 For example, Hirst (1994), pp.212-3.

52 D. Green, 'Reinventing civil society'; *Idem*, 'Medical care without the state', in A. Seldon (ed.), *Reprivatising welfare* (London, 1996), pp. 21-38; A. Seldon, *The litmus papers*.

53 R. Pinker, *English hospital statistics, 1861-1938* (London, 1964); PEP, *Report on the British health services* (London, 1937).

little sense of spatial variation. Nor did Pinker offer statistics on the capital accounts and overdrafts of hospitals, although such resources were crucial in terms of helping hospitals to withstand financial pressures.

The PEP report also relied on national aggregate statistics but gave more attention to issues of finance and management. It contended that while the voluntary hospitals had ‘faced tremendous financial problems’ in the inter-war years, the majority had ‘temporarily overcome’ (our emphasis) their financial difficulties. Like Pinker, PEP’s analysis of the hospitals’ sources of income emphasised that charity had been undermined as ‘other claims and increased taxation had levied a toll’. Thus, income from philanthropy (subscriptions, donations and legacies) had risen but had ‘not been rising fast enough’⁵⁴ to keep pace with growing demand. Traditional sources of income could therefore no longer maintain the system and it was only the growth of patient payments and of hospital contributory schemes which kept hospitals afloat financially. It was the growth of these new arrangements which was evidence to Green of the vitality of the sector.

Other historians are less certain. There is a widely held view that ‘severe financial problems’ confronted the hospitals by 1939⁵⁵. Abel-Smith, the author of the standard textbook on British hospitals, observed that in the interwar period they had lost their primarily charitable character⁵⁶. This view is echoed by Webster, the official historian of the NHS, who suggested that by the 1940s the voluntary system was becoming financially unviable and voluntary in name only⁵⁷. The clearest defence

⁵⁴ *Ibid.*, p. 232.

⁵⁵ R. Lowe, *The Welfare State in Britain since 1945* (London, 1993), p.169.

⁵⁶ B. Abel-Smith, *The hospitals, 1800-1948* (London, 1964), p. 338.

⁵⁷ C. Webster, *The health services since the War: Volume I, Problems of health care, The National Health Service before 1957* (London, 1988), pp. 23-31.

of charity's enduring strength has been made by Prochaska, who argues that, for the 1920s at least, reports of its demise rested on a partial and selective reading of hospital accounts, which neglected the significance of extraordinary income (such as legacies), and endowment income (interest, dividends)⁵⁸. If these are considered then charitable sources continued to provide the greater part of hospital income as late as 1929. These different perspectives, founded on limited snapshots of aggregate income, raise important questions about the hospitals' financial health. What potential did charity still have in the early 20th century to finance hospital services? Could the new methods of finance – fees and contributory schemes – have provided a viable alternative, or was state intervention essential?

Historical experience might also shed light on the extent to which voluntarism provided a comprehensive service. Green believes that it did, but his approach to this question is not fully convincing. For instance, he suggests that on the basis of hospital-based treatment statistics, up to 25% of the population of London received outpatient care in 1907⁵⁹, but this takes no account of the large inflows of patients from the Home Counties. He subsequently presents estimates for the coverage of the health care system in 1939 which neglect the possibility of considerable overlap between various categories of services. He contends that, of the British population of 46.5 million, 19 million were covered by national insurance and that the outpatient departments of voluntary and public hospitals must have served about 6 million (the basis of the latter figure is not given). Other categories, totalling 8.2 million, include those

58 F. K. Prochaska, *Philanthropy and the hospitals of London: The King's Fund, 1897-1990* (Oxford, 1992), pp. 90-4, 101-2, 104.

59 D. Green, *Reinventing civil society*, pp. 71-2.

catered for by charitable and provident dispensaries (300,000), the lodges (1.5 million), fee-for-service insurance (2 million), public medical services (1.2 million) and works clubs, including medical aid societies (3 million). A further million were covered by unregistered friendly societies. This leaves some 12 million who, according to Green, would have paid private fees⁶⁰. There are difficulties with these figures. Most of the categories referred to involved different forms of financing primary care, rather than hospital treatment. However, we do not know whether there was overlap between the categories. Even if minimal, that still leaves the 6 million hospital outpatients. If these were all attending because they had no access to primary care it raises the question of what hospital outpatient departments were for. If they were attending for treatment which was only available in hospitals, that leaves a gap in Green's figures for access to primary care. He also makes the (rather heroic) assumption that the 12 million people not covered by various services would have paid for treatment privately⁶¹. Even if we accept these assertions at face value, no reference is made by Green to variations in the availability of services and in their quality. Instead Green stresses the desirability of services reflecting local preferences, and justifies 'taking the risk of under-government'⁶² in order to allow for local control. It is therefore of considerable interest to establish more clearly the nature of geographical disparities in the pre-NHS system and to gauge the extent to which this was indeed a reflection of local wishes.

In summary, there are compelling arguments from several points of the political compass for a revived voluntarism but,

60 D. Green, *Reinventing civil society*, pp. 105-6.

61 Susannah Morris, 'Defining the non-profit sector: some lessons from history', *Civil Society WP-3* (LSE, 2000), p. 9.

62 D. Green, *Reinventing civil society*, p. 20.

34

with the exception of some neo-liberal analysts, relatively limited use has been made of the historical record to advance these debates. Is it now, as one pundit claims, the received wisdom that the voluntary hospitals 'provided a safeguard against overbearing officialdom' and 'exemplified democratic pluralism, local independence and self-help'⁶³? Or should we be more sceptical of nostalgic evocation of a golden age that never existed?

63 M. Phillips, 'Opinion', *The Observer* (22 June, 1997).

3 REASSESSING THE LEGACY OF VOLUNTARISM

Even though they did not provide the majority of beds, the growth of the British voluntary hospitals remains one of the extraordinary achievements of the ‘third sector’. This chapter surveys the hospitals’ performance in the first part of the 20th century, as they grappled with the challenge of providing mass health care within a mixed economy of welfare. Many of the findings are based on a recently created database of the pre-NHS hospital system, which permits more extensive quantitative analysis than has been possible hitherto. We have also investigated in detail the finances and management of a sample of hospitals in contrasting locations⁶⁴. We draw on quantitative and qualitative research to analyse comprehensively the state of the voluntary hospital movement at the end of the 1930s – when policy-makers began to consider seriously the rejection of voluntarism.

We begin with a brief historical overview of the voluntary and public hospital sectors. Next, we discuss trends in voluntary hospital finance, followed by an analysis of patterns of provision and utilisation. Subsequent sections consider issues of accountability, democracy and planning. This structure allows us to focus on key themes of equity, financial stability, accountability and planning, and permits parallels with the contemporary situation to be drawn.

⁶⁴ Further details of this project are available from the authors, but at its core is a database containing information on more than 1,000 voluntary hospitals for selected years from 1891-1944. For the majority of hospitals data are available on bed provision and occupancy, patients treated and income/expenditure. For a subset (typically the largest 150-200 hospitals) much more detailed data are available on sources of income, components of expenditure, and comparative costs. The database also includes items such as foundation dates, hospital type and one-off surveys of medical staffing. Finally, for comparison, there are some statistics (post-1929) on local authority provision.

3.1 The voluntary and public hospital sectors: an historical overview

What exactly does the term ‘voluntary hospital’ signify? In the early 20th century it was understood to denote an independent institution with three key features. Income was drawn not from the public purse but from philanthropy (and, later, from mass contributory schemes). Management was in the hands of a volunteer governing body which was accountable only to the subscribers, and medical care was provided principally by honorary consultants who were not paid by the hospital⁶⁵. The first wave of voluntary foundations in London and the provincial cities took place during the 18th century, when the new fashion for subscriber charity superseded the traditional philanthropic form of the endowed trust⁶⁶. Subscribers were issued with admission tickets which they could dispense to applicants desirous of treatment in the hospital; accident and emergency patients were admitted automatically. The rhetoric of early hospital appeals suggests donors’ motives could range from religious duty to a desire for moral reform, but a central concern was the speedy return to productive employment of male breadwinners. Sickness of the wage-earner both threatened fragile household economies and imposed a burden on local tax-payers if families were obliged to turn to the Poor Law for support. Admissions

65 British Hospitals Association (BHA), *Report of the Voluntary Hospitals Commission* (London, 1937); Political and Economic Planning (PEP), *Report on the British health services* (London, 1937), pp. 16-17, 230-240; J. E. Stone, *Hospital organisation and management* (London, 1927), p. 12. As we show below, with the increase of pay beds in the early 20th century, consultants could receive fees direct from paying patients.

66 R. Porter, ‘The gift relation: philanthropy and provincial hospitals in 18th century England’, in L. Granshaw and R. Porter, eds., *The hospital in history* (London, 1989), pp. 149-78; B. Abel-Smith, *The hospitals 1800-1948* (London, 1964), pp. 4-15.

were typically limited to younger adults suffering from non-infectious acute diseases, amenable to reasonably rapid courses of treatment⁶⁷.

In the first half of the 19th century general hospitals opened in most large towns, while specialist institutions (maternity; ophthalmic; ear, nose and throat; etc.) also emerged. The late 19th century saw this development continue, along with the appearance of the cottage hospital movement, promoting small establishments in rural areas⁶⁸. From an early stage medical education was a feature of the largest voluntary hospitals, with honorary consultants supplementing their income by apprenticeship fees for clinical teaching⁶⁹. Links with medical schools were subsequently formalised. By the early 20th century, the transition of hospitals from primarily philanthropic to primarily medical institutions was apparent⁷⁰. The 31 teaching hospitals were centres of medical research and scientific advance; honorary staff held posts in local university medical schools, and the introduction of bacteriology and pathology laboratories had begun to shift both clinical training and diagnostic practice from bedside to bench⁷¹.

Not all hospital beds were in voluntary institutions; indeed they remained a minority before 1948, overshadowed by publicly funded provision. The Poor Law had historically per-

67 M. E. Fissell, *Patients, power and poor in eighteenth century Bristol* (1991); J. Woodward, *To do the sick no harm* (London, 1974), pp. 36-74.

68 S. Cherry, 'Change and continuity in the cottage hospitals c. 1859-1948', *Medical History* (1992), 36, 271-89.

69 M. E. Fissell, ch. 7; B. Abel-Smith, *op. cit.* (1964), pp.16-31.

70 K. Waddington, *Charity and the London hospitals, 1850-1898* (Woodbridge, 2000).

71 S. Sturdy and R. Cooter, 'Science, scientific management and the transformation of medicine in Britain, 1870-1950', *History of Science* (1998), xxxvi, pp. 421-66.

formed a medical function, and Victorian workhouses accommodated the sick alongside the aged, the 'lunatic' and the destitute; by the early 20th century 30% of Poor Law beds were in separate infirmaries⁷². The standard of care was generally inferior to the voluntaries, typically addressing the elderly, long-stay patient suffering a chronic illness; staff-patient ratios were worse, and the practice of delegating nursing care to untrained pauper inmates was slow to change⁷³. In addition local authorities had, since 1867, built publicly funded hospitals to address infectious diseases: principally isolation hospitals for scarlet fever and diphtheria, and tuberculosis sanatoria. In 1929 public provision was restructured when the Local Government Act broke up the Poor Law and brought its institutions within the purview of the local authority. This Act also empowered councils to open municipal general hospitals, whose ambit included the non-pauperised acute and maternity patients who hitherto had been treated in the voluntaries⁷⁴. The distinction between the voluntary and public sectors was never absolute. Parishes and Poor Law Unions sometimes numbered amongst voluntary subscribers, and the War Office funded venereal disease wards in some hospitals in naval towns⁷⁵. After 1918 local authorities developed contracting arrangements with voluntary hospitals to perform their statutory duties with respect to tuberculosis, maternity and child welfare, and venereal disease. In both

72 M. A. Crowther, *The workhouse system 1834-1929* (London, 1981), p. 186.

73 A. Digby, *Pauper palaces* (London, 1978), pp. 171-2; M. A. Crowther, *op. cit.* (1981), pp. 162-6, 182-90; R. Pinker, *English hospital statistics, 1861-1938* (London, 1966), pp. 110-2.

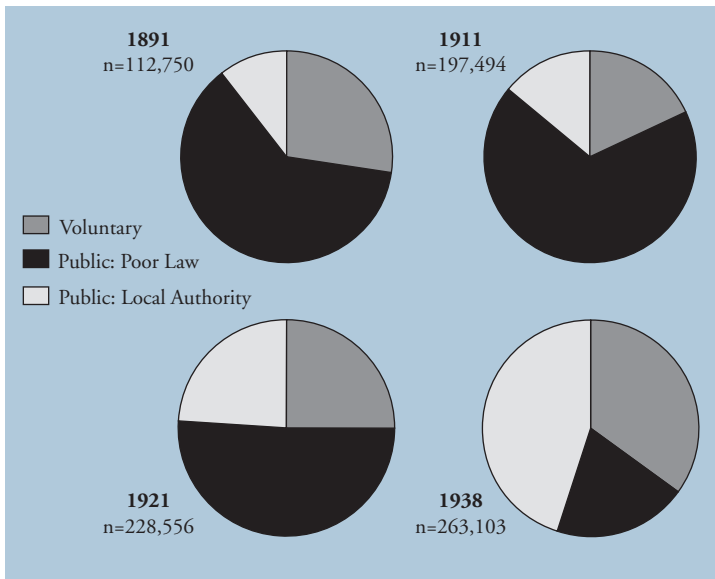
74 M. Powell, 'An expanding service: municipal acute medicine in the 1930s', *Twentieth Century British History* (1997), 8, 334-57; B. Abel-Smith, *op. cit.* (1964), pp. 368-83.

75 A. Digby, *op. cit.*, 169; J. Walkowitz, *Prostitution and Victorian society: women, class and the state* (Cambridge, 1980), pp. 215-20.

world wars the voluntaries were integrated in emergency medical schemes managed by the state.

Precise estimates of the sectoral shares of beds are hard to make, given the extent of ‘mixed’ accommodation in work-houses, but Pinker’s analysis of sporadic official returns reveals the situation between 1891 and 1938 (Figure 3.1). The overall dominance of the public sector is evident, with an ever-increasing proportion of beds located in the local authority hospitals, particularly by 1938 when the Local Government Act had begun to take effect. It is also clear that the inter-war period was a time of considerable expansion for the voluntaries, whose share of total beds increased.

Figure 3.1 **The distribution of hospital beds in the public and voluntary sectors, England and Wales, 1891-1938**



Source: R. Pinker, *English hospital statistics 1861-1938* (London, 1966), pp.61-2.

3.2 Voluntary hospital finance

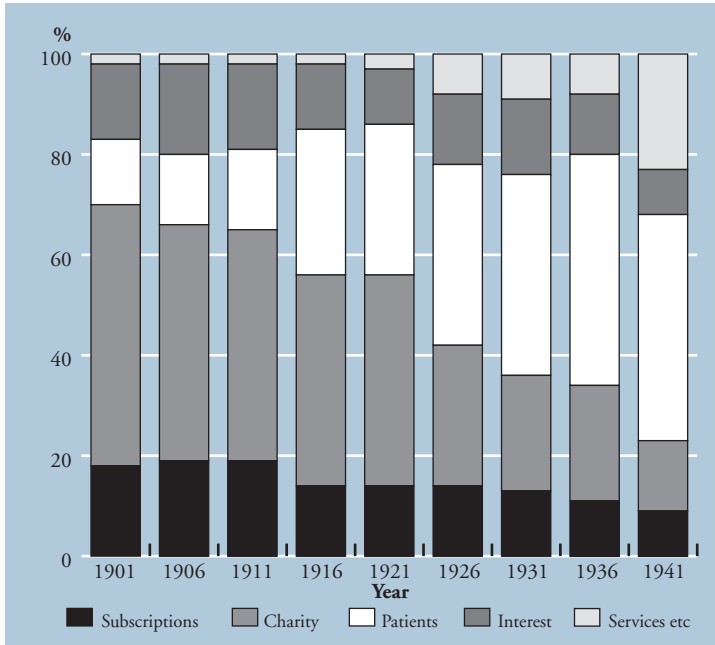
How, and with what success, was the voluntary hospital financed in the absence of support from taxation? The analysis here will focus on the period 1900 to 1938, the last year of peace before the wartime emergency. Given the expansion in bed numbers recorded in Figure 3.1 (the 'n's), it is not surprising that income also grew impressively between these two years. The total annual income of British voluntary hospitals in 1901 was £2.1 million, rising to £15.4 million by 1938, or, if adjusted to take account of price changes, £6 million rising to £27 million, at 1948 prices⁷⁶. In London, where about one in four of the nation's hospital beds were located, annual income grew from £2.6 million in 1921 to £4.7 million in 1938 (£3 million to £8 million at 1948 prices)⁷⁷. This was by no means a smooth process, and in the immediate aftermath of the First World War it had appeared to many that state funding must supersede voluntary sources if the hospitals were to survive. Financial crisis was most intense in the years 1918 to 1921, when a concatenation of pressures faced the hospitals. Philanthropy was at a low ebb as the wealthy were now liable for unprecedented levels of income tax and death duties. Post-war inflation pushed up the prices of fuel and provisions. Essential building and maintenance had been postponed during the wartime emergency and now had to be addressed. To compound all this, the influenza pandemic placed heavy pressure on staff and accommodation⁷⁸.

⁷⁶ The sources for these figures are *Burdett's hospitals and charities* (for 1901) and the *Hospitals yearbook* (1931, 1938).

⁷⁷ KF (King Edward's Hospital Fund for London), *Statistical report* (later *Statistical summary*) 1921-42; income totals for the capital were not given prior to this point.

⁷⁸ B. Abel-Smith, *op. cit.* (1964), pp.307-9, 323-4; S. Cherry, 'Before the NHS: financing the voluntary hospitals, 1900-1939', *Economic History Review* (1997), L, 305-26, 312.

Figure 3.2 **Composition of voluntary hospital income: England (excluding London), Scotland and Wales, 1901-1941**



Sources: *Burdett's hospitals and charities*, the *Hospitals yearbook* and the *Order of St. John's annual reports on the voluntary hospitals of Great Britain*.

The government therefore established the Cave Committee in 1921 to report on the hospitals' problems and recommend solutions. The result was a Treasury grant of £500,000, dependent on matching funding being obtained from voluntary sources⁷⁹. This was duly found and distributed, and by the mid-1920s the crisis had been overcome and the voluntary system preserved.

None the less, the First World War was a turning point and the subsequent growth in income was sustained by a changed

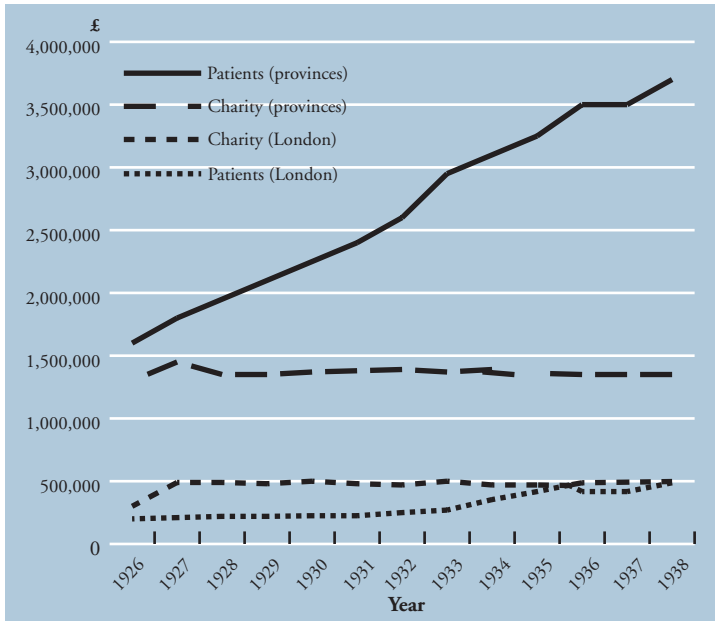
⁷⁹ Stone, *op. cit.*, pp.45-8.

mix of funding sources. Figure 3.2 illustrates the composition of annual income in British hospitals, based on the returns of current account data reported in three series of hospital year-books⁸⁰. London is excluded from this illustration as after 1923 the capital's statistics were drawn from the King's Fund Abstracts, which did not disaggregate charitable income to the same level of detail. The categories of 'subscription' (an annual pledged sum) and 'charity' (donations, legacies, church collections, fund-raising events) had been the original mainstay of income. These underwent a long-run decline, first clearly noticeable at the time of the 1914-18 War, and broken only with a brief resurgence in the early 1920s when renewed philanthropic benevolence was crucial to overcoming the post-war funding crisis. The category of 'patients', which after 1914 bulked ever larger, is composed of both direct payment by patients and income from mass contributory schemes. Direct payment took the form either of a charge made on the better-off patients for the cost of hospitalisation, or of a sum levied by the hospital almoner according to the patient's means. The contributory schemes had developed from workplace funds supported by small subscriptions, but flourished from the 1920s when they were promoted by the hospitals themselves in a bid to broaden their base of support during the funding crisis of 1918-21⁸¹. 'Interest' refers to annual yields on assets, mostly gilts and equities, but sometimes property too; this remained a stable proportion of total income. 'Services' includes money earned from home nursing and fees paid by local and national government. Growth in this category after 1921 represents the

80 These are *Burdett's hospitals and charities*, the *Hospitals yearbook* and the *Order of St. John's annual reports on the voluntary hospitals of Great Britain*.

81 S. Cherry, 'Beyond national health insurance: the voluntary hospitals and hospital contributory schemes', *Social History of Medicine* (1992) 5, pp. 455-82.

Figure 3.3 **Income from charity and patients in selected hospitals, 1926-1938, at 1938 prices**



Sources: *Burdett's hospitals and charities*, the *Hospitals yearbook* and the *Order of St. John's annual reports on the voluntary hospitals of Great Britain*.

local authority subventions mentioned above, and the increase in 1941 reflects the state payments made under the wartime Emergency Medical Service.

What did this mean in real terms in the final years of the voluntary hospitals? Figure 3.3 shows trends between 1926 and 1938 in the two main components of income, 'charity' (here including subscriptions) and 'patients', in hospitals for which consistent income data have been obtained. These consist of 53 provincial general hospitals accounting for about 25% of all beds outside the capital and 13 London hospitals, including five

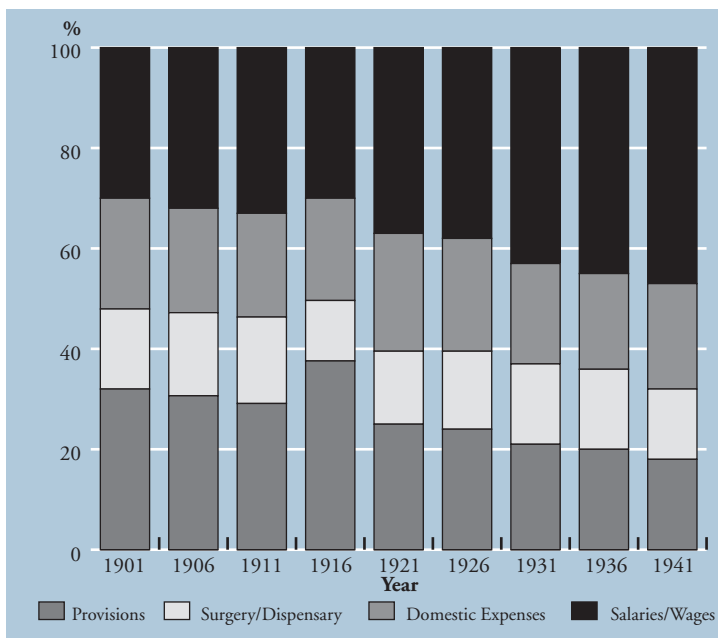
medical schools and the four largest general and special hospitals, again representing about 25% of the city's beds. The figures are adjusted to constant 1938 prices. While charity had not actually gone into decline, it clearly failed to expand at the rate required to meet expenditure demands. In the provinces income from patients far surpassed that of charity, and was the key to the growth of the system. In London it also grew significantly over the period, but here charitable finance, though broadly static, remained the dominant component. This was despite the fact that the country's largest contributory scheme, the Hospital Saving Association (HSA), was based in the capital. Started in 1923 with a grant from the King's Fund, the HSA elicited regular contributions of 3d (£0.0125) per week from families on a 'limited income' (a maximum of £6 per week for a couple with children), which guaranteed them exemption from charges or means-testing for hospital treatment⁸². However, its impact was dissipated amongst the large number of institutions in London. Traditional modes of charity were also more robust, with fund-raising activities remaining a vital part of the social round of the metropolitan elite⁸³.

What were the main expenditure demands driving these developments? Figure 3.4 examines the most significant items of spending over the longer term, again drawing on the year-book totals. There were four major categories: 'provisions' (food and drink), 'salaries and wages' (pay of nurses, ancillary staff and medical residents); 'domestic' (fuel, cleaning and general upkeep) and 'surgery/dispensary' (drugs, dressings, and instruments). Not shown here are the various administrative costs and the 'extraordinary' expenditure on equipment, buildings and fund-raising that fell outside anticipated current account

82 Stone, *op. cit.*, pp.221-5; PEP, *op. cit.*, pp. 234-5.

83 M. Gorsky and J. Mohan, 'London's voluntary hospitals in the inter-war period: growth, transformation or crisis?', *Nonprofit and Voluntary Sector Quarterly*, forthcoming, 2001.

Figure 3.4 **Main categories of voluntary hospital expenditure: England, Scotland and Wales, 1901-1941**



Sources: *Burdett's hospitals and charities*, the *Hospitals yearbook* and the *Order of St. John's annual reports on the voluntary hospitals of Great Britain*.

spending: changing accounting practices mean that these were not recorded in a consistent fashion⁸⁴. Indeed, the period saw considerable capital spending on infrastructure which is not captured in the national aggregates recorded in the yearbooks. In addition to new wards this included the equipping of specialist departments and laboratories, X-ray and radiology appli-

⁸⁴ On the evidence of those years in which they were recorded separately, the various administrative expenses probably account for some 20% of annual 'maintenance costs'.

ances, as well as telephone systems, electrification, lifts and steam laundries⁸⁵. However, the concern here is the narrow issue of annual current expenditure – which the hospitals termed ‘maintenance’.

In terms of current expenditure two features stand out. There was a short-term rise in the proportion of the budget spent on provisions during the 1914-18 war and its aftermath, a key factor in the post-war crisis noted above. The more significant long-run trend was the rising share of the budget spent on staffing, which accounted for 48% of the main expenditure items by 1941. The explanation for this does not lie in the greater cost of salaried doctors, although it had become more common for even smaller hospitals to employ medical residents. Instead it was the improved conditions for nurses and ancillary workers, in the form of wages, pensions and shorter hours, which drove up spending⁸⁶. Even though nurses’ pay and conditions remained less attractive than in other white blouse occupations, their growing professional assertiveness, coupled with a tight labour market and rising salaries in the public hospitals, won them a larger share of the staff budget⁸⁷. Further pressure was applied by the advance of specialist treatments, ranging from orthopaedic clinics to radiology departments which required a higher degree of training and hence remuneration⁸⁸.

With what success did hospital fund-raising meet these rising expenditure demands? Figure 3.5 surveys the situation in the voluntary hospitals’ final peacetime decade, showing the

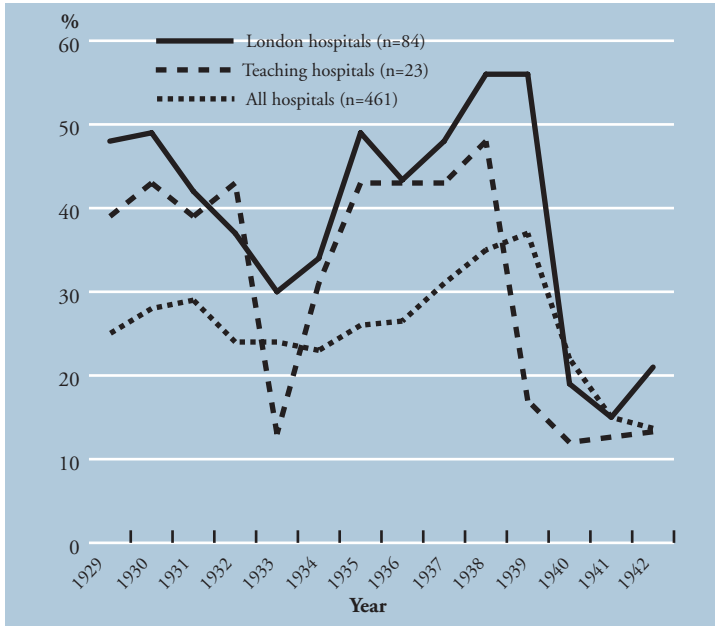
85 R. Cooter, ‘The politics of a spatial innovation: fracture clinics in inter-war Britain’, in J. Pickstone (ed.), *Medical innovations in historical perspective* (London, 1992), pp. 146-64; Dow and Lenihan, ‘The impact of technology’, in G. MacLachlan (ed.), *Improving the common weal: aspects of Scottish health services* (Edinburgh, 1987), pp. 505-28; S. Sturdy and R. Cooter, *op. cit.*

86 Stone, *op. cit.*, p. 572.

87 B. Abel-Smith, *A history of the nursing profession* (London, 1960), pp. 120-2, 276-83.

88 R. Cooter, *op. cit.*, p. 147.

Figure 3.5 The proportion of voluntary hospitals with current account deficits: England, Scotland and Wales, 1929-1942



Sources: *Burdett's hospitals and charities*, the *Hospitals yearbook* and the *Order of St. John's annual reports on the voluntary hospitals of Great Britain*.

extent of deficits in 461 institutions which reported consistently to the yearbooks. Deficits are understood here as an excess of annual expenditure on maintenance over income received, as recorded in the 'income and expenditure' account⁸⁹. Of course, a deficit need not necessarily indicate that financial difficulties were looming; indeed some hospital treasurers believed that a

⁸⁹ Sometimes termed the 'Current' or the 'Maintenance' account, this showed actual income and expenditure in the calendar year, irrespective of when the items were actually received or paid for. See *The revised uniform system of hospital accounts*, 4th Edition (London, 1926), pp. 4-17; R. Pinker, *op. cit.*, pp. 143-7.

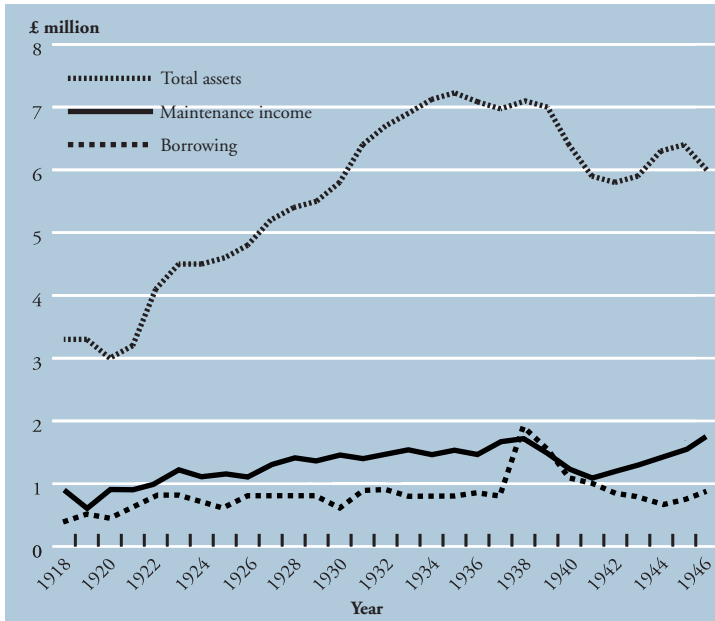
moderate shortfall presented in the annual report encouraged greater generosity from prospective donors⁹⁰. However, consideration of a sufficiently large number of hospitals does reveal a broad trend of growing financial hardship through the 1930s. After rising during 1929-32, the years of economic slump, the proportion of hospitals in deficit fell until the mid-1930s, before rising again up to 1939, at which point more than one third of all the hospitals in the set reported deficits. The situation was eased only with the onset of the wartime emergency scheme, when state support brought the proportion in deficit down to a lower level than at any time since 1929.

Throughout most of the period the teaching hospitals were rather more at risk of income shortfall than were other hospitals. Although by 1933 the teaching hospitals had recovered their position in the wake of the slump, their situation worsened through the mid-1930s, and almost half of them were in the red in 1938. Prevalence of deficits could also vary with location, and London, home to so many teaching, special and large general hospitals, was particularly vulnerable. Contemporaries were certainly aware of the differences between the financial burdens faced by hospitals with a medical school attached, and the typically more comfortable position of the smaller cottage hospitals⁹¹. Not shown here is the extent to which deficits recurred in the same hospitals. This was quite variable: in London for instance five hospitals had only one deficit year, while four had deficiencies in 11 of the 14 years shown. Again, contemporaries recognized the problem: the British Hospitals Association (BHA), the voluntary sector's

90 For example, Aberdeen Children's Hospital regularly showed a deficit in the 1920s by carrying a proportion of income from interest on property over to its capital account, see *'Royal Aberdeen Hospital for Sick Children, Directors' minute book'*, archives of Grampian Regional Health Board, ref 5/1/6: 29 January, 1924, 4 February 1926, 27 January, 1927.

91 BHA, *op. cit.*, p.51; BHA, *Voluntary Hospital Commission proceedings, 1936-7*, British Library of Economic and Political Science, ref BHCSA 3/9, 24 June 1936.

Figure 3.6 Capital assets and borrowing in five London teaching hospitals, 1918-46, at 1948 prices



Sources: Hospital annual reports held in London Metropolitan Archives, class number SC/PP5/093.

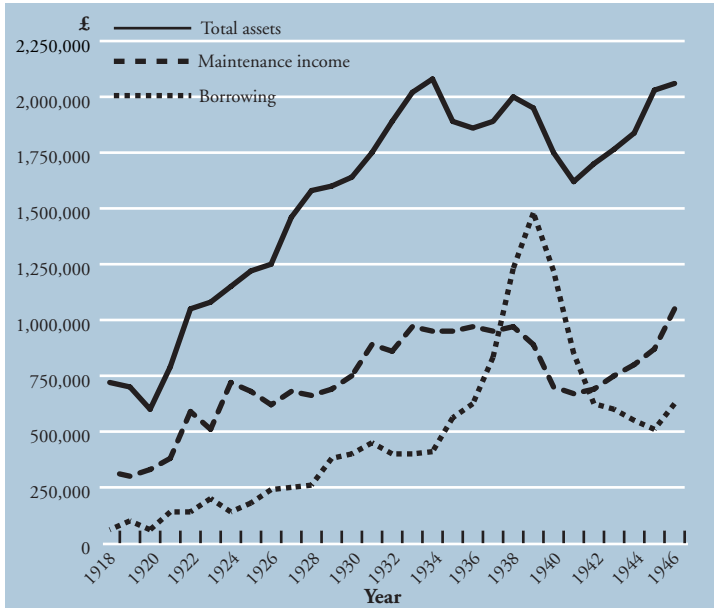
mouthpiece, noted in 1938 that ‘the position of hospitals with persistent annual deficits (was) one of particular urgency’⁹².

To complete this survey of the strength of voluntary finances prior to the NHS it is necessary finally to consider the state of the hospitals’ capital reserves. As noted, capital accounts are absent from the aggregate statistics collected in the national yearbooks, although it is possible to trace the decline of capital receipts (‘extraordinary’ income) as a proportion of total income in the 1930s. This strongly suggests a ‘deteriorating financial base’⁹³.

92 BHA, *op. cit.*, p.27.

93 S. Cherry, *op. cit.*, (1997).

Figure 3.7 **Capital assets and borrowing in eight London general and special hospitals, 1918-46, at 1948 prices**



Sources: Hospital annual reports held in London Metropolitan Archives, class number SC/PP5/093.

However, individual hospitals did record both the value of their accumulated assets and their borrowing. Figure 3.6 draws on the data from five London teaching hospitals while Figure 3.7 is based on the capital's eight largest general and special hospitals. Taken together the 13 hospitals accounted for just under 25% of all London hospital beds⁹⁴. The assets shown are the investments

94 Teaching: Guy's, St Thomas's, Westminster, King's College, London. General: Royal Northern, Prince of Wales General, West London, Queen Mary's Hospital for the East End. Special: Hospital for Sick Children, Queen Charlotte's Maternity, National Hospital for Consumption and Diseases of the Chest, National Hospital Queen Square. The annual reports which are the sources of the data are held in London Metropolitan Archives, class number SC/PP5/093.

on the hospital's capital account, consisting both of gifts protected by a trust, which the hospital could not sell, and unprotected general gifts which the hospital was free to use for current expenditure if it wished. They exclude items such as cash in hand, uncollected debts and fixed assets of buildings and plant, which were not always recorded in the capital account.

Despite the general economic slump which began in 1929 the asset base of both teaching and non-teaching hospitals grew impressively until the middle of the 1930s, at which point it levelled off in the teaching hospitals and declined in the others. The striking growth that was enjoyed even through the slump was due not only to the generosity of testators, but also to the trustees' policy of cautious investment, underpinned by a statutory obligation to invest certain types of charitable trust funds in fixed interest Exchequer or War Bonds⁹⁵. However, as comparison of the figures demonstrates, the wealth of the five teaching hospitals far exceeded that of the eight largest general and special institutions. The value of borrowing, shown here at constant 1948 prices, increased in the teaching hospitals from about £370,000 in 1918 to a peak of just under £2 million in 1938. In the non-teaching hospitals, debt rose from about £60,000 in 1918 to reach nearly £1.5 million in 1939. Although the level of borrowing ranged between 10% and 25% of the value of assets through most of the period, it remained high when set against annual income, which it outstripped in the late 1930s. Indeed, by 1939 the level of debt in the eight general and special hospitals amounted to 76% of the value of their assets. This alarming situation was only ameliorated by government grants under the wartime Emergency Medical Services scheme.

Consideration of the hospitals' asset base therefore broadly confirms the scenario suggested in Figure 3.5 of a worsening

⁹⁵ Stone, *op. cit.*, pp. 531-8.

financial position from the mid-1930s until the outbreak of the Second World War. With respect to the teaching hospitals though, a rather more complex situation obtained. Guy's Hospital for example had six years of current account deficit in the thirties, and borrowed heavily to finance development, with debts in excess of £200,000 by 1931. However, with assets accumulated over two centuries, and worth about £1.3million by 1939, its borrowing remained well within the limits of what it could afford. Similarly, the dramatic leap in borrowing in the late 1930s shown in Figure 3.6 marked the culmination of a major building project at the Westminster Hospital, which was well-supported by a special appeal that rapidly began to repay the loans. King's College Hospital was a teaching hospital in a less fortunate position. It had relocated to South London before the war and struggled both to complete the programme of expansion on the new site and to meet the ever increasing running costs. By 1939 its borrowing stood at £55,000, and although it held assets of almost £250,000, these were predominantly trusts protected from sale. Its disposable wealth was virtually all spent, as 'free' assets had been regularly realized to cover the deficits on the maintenance account⁹⁶. Some of the general and special hospitals faced even more serious crises. For instance, the Royal Northern Hospital, which had expanded its inter-war bed capacity by 134% to cater to demand in the residential suburbs, saw its level of borrowing far exceed its disposable assets.

In summary, the inter-war period saw growth, transition and persistent difficulties in the financing of voluntary hospitals. Costs were driven up by the massive expansion of provision, the burgeoning staffing budget, the modernisation of the institutional fabric and the need to exploit new medical technologies. Traditional modes of hierarchical charity were insufficient to sustain these demands. Personal taxation had risen to unprecedented-

96 King's College Hospital *Annual report*, 1931, 1932, 1936.

Box 3.1 **Voluntary hospital finance 1900-1938**

- Total annual income of British voluntary hospitals more than quadrupled in real terms.
- Outside London the proportion of funding coming from charitable sources (including subscriptions) declined from over 70% of voluntary hospitals' income to around a quarter.
- There was also a proportionate decline in charitable funding of voluntary hospitals in London, but a more gradual one.
- Greatly increased direct payments by patients and income from mass contributory schemes made up the difference in both cases.
- But costs also increased rapidly, particularly staffing costs.
- In the decade before the Second World War growing numbers of voluntary hospitals were in financial deficit: more than one third of them by 1939.
- This situation was eased only with the onset of the state-financed wartime emergency scheme.

ed levels, while the emergence of tax-funded municipal general hospitals after 1929 further undermined philanthropic impulses; this in turn eroded the asset base. Survival therefore depended on a creative and flexible response by voluntary fund-raisers. This took the form of a new reliance on private payment and a shift to mass contributory arrangements, whose success was founded upon the local loyalties which voluntary hospitals inspired. However, the late 1930s saw financial crisis looming, as current account deficits multiplied and some institutions sank seriously into debt. For many hospitals the problems of reconciling charitable insufficiency with public expectation proved too great, and were resolved only by government aid in the wartime emergency.

3.3 The geography of the voluntary hospital

a. Hospital provision

A major strength of the voluntary sector is localism: the ability

to marshal sentiment at the level of town, county or region behind forms of social action which do not command sufficient support to legitimate statutory public provision. There were no national or regional bodies involved in the planning of the voluntary hospital network, at least until the establishment of the King's Fund (originally the Prince of Wales's Hospital Fund for London) in 1897 and the Nuffield Provincial Hospitals Trust in 1939. Instead hospital establishment depended entirely on the motivations of local elites: doctors, church-leaders, businessmen and professionals with an interest in civic affairs. Foundations were typically the initiative of wealthy citizens, perhaps eager to emulate the institutional glories of other cities, or animated by personal or family experience of ill health and recovery which prompted direct benevolence to a hospital. The first step was the constitution of a trustee body and the organisation of an initial round of subscription and donation to raise funds for the building. Alternatively, this might be led by medical men arguing that the prevalence of disease necessitated such intervention⁹⁷. In some locations the concern of industrialists for the protection of their human capital was a key issue⁹⁸. In other places the tenor of local politics could play a part, either when factions of party and sect used philanthropy to advance their own position, or when joint philanthropic projects were initiated to promote civic unity over factionalism⁹⁹.

97 C. Webster, 'The crisis of hospitals during the Industrial Revolution', in E. G. Forbes (ed.), *Human implications of scientific advance* (Edinburgh, 1977), pp. 214-23.

98 H. Marland, *Medicine and society in Wakefield and Huddersfield, 1780-1870* (Cambridge, 1987), pp. 117-45.

99 A. Wilson, 'Conflict, consensus and charity: politics and the provincial voluntary hospitals in the eighteenth century', *English Historical Review*, cxi, 599-619; M. Gorsky, *Patterns of philanthropy: charity and society in nineteenth century Bristol* (Woodbridge, 1999), pp. 152, 198-200.

In these circumstances the scope for individual agency in determining the timing and location of foundations was very wide. For example, many special hospitals owed their existence to enterprising doctors seeking to establish a career niche for themselves in what, in the Victorian period, was an overcrowded and fiercely competitive profession¹⁰⁰. Smaller hospitals were often dependent initially on a single leading donor, an industrialist or land-owner, who chose at a given point to fund an institution. Lock hospitals, treating sexually transmitted diseases, tended to be located in towns where the armed forces were concentrated, such as Plymouth and Portsmouth. These were sometimes promoted by female 'social purity' campaigners, as in the case of Bristol where the foundation grew out of a strong network of women's activism¹⁰¹. Expansion of existing accommodation could also hinge on the unanticipated largesse of a single donor. At the Aberdeen Royal Infirmary for instance, a new wing was opened in 1912 following a surprise gift from Lord Mount Stephen, who, prior to making a fortune in railway speculation, had once been successfully treated in the hospital¹⁰².

Since the spontaneity and vagaries of individual and local philanthropy were inherent features of the voluntary system, hospital facilities were distributed in an uneven manner across the country and there were varying degrees of mismatch between provision and need. From the outset the relationship between the siting of institutions and population density was irregular, as Table 3.1 shows. After about half a century of foundations four of the 20 largest towns (Plymouth, Coventry, Portsmouth, Ashton-under-Lyne) remained without accommo-

100 Granshaw, *op. cit.*; I. Loudon, *Medical care and the general practitioner 1750-1850* (Oxford, 1986), ch. 10.

101 Walkowitz, *op. cit.*, 121, pp. 130-1.

102 N. Logie, 'History of the Aberdeen joint hospital scheme and site', in G. P. Milne, *Aberdeen Medico-Chirurgical Society: a bicentennial history, 1789-1989* (Aberdeen, 1989), pp. 155-78.

Table 3.1 The diffusion of English hospital foundations down the urban hierarchy by 1801

<i>Town rank by size</i>	<i>Population '000</i>	<i>Number of hospitals:</i>		
		<i>general</i>	<i>special</i>	<i>total*</i>
1 (London)	c.900	6	7	13
2-10	32-78	6	3	9
11-20	15-32	8	2	10
21-30	12-15	3		3
31-40	10-12	2		2
41-50	8.8-10	3		3
51-60	7.6-8.7	1		1
61-70	7-7.5	3		3
71-80	6.4-7	3		3
81-90	5.8-6.4	1		1
91-100	5.4-5.8	1		1
Total		37	12	49

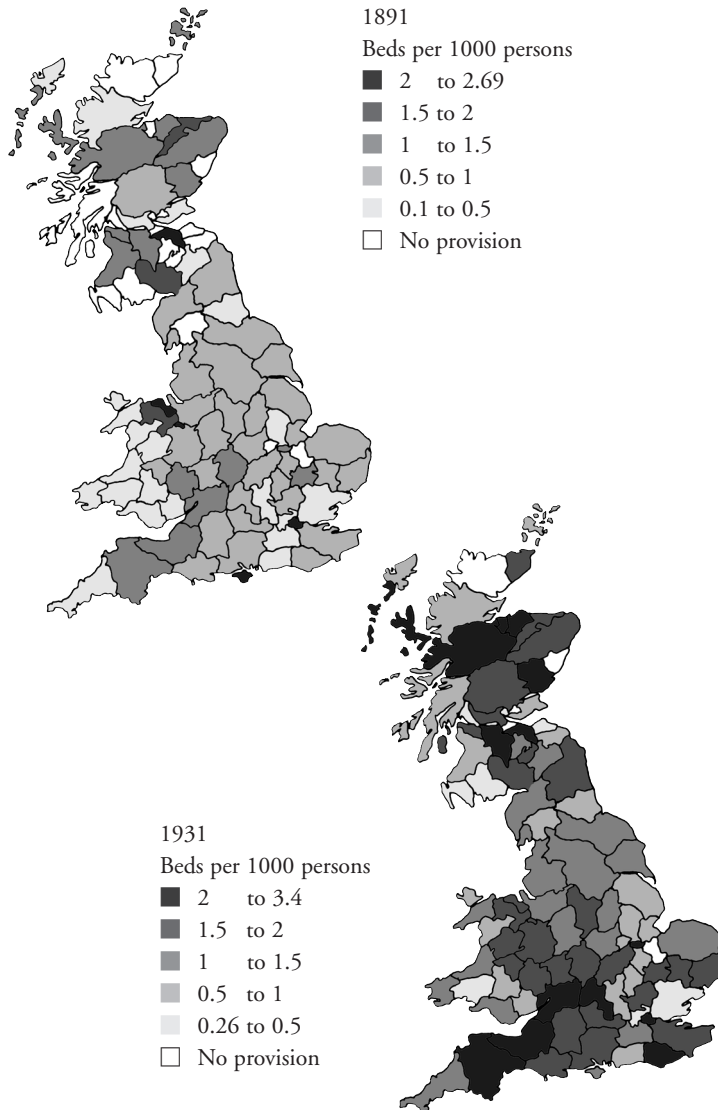
*NB All voluntary hospitals founded in England by 1801 and still extant in the 1930s.

Sources: *Burdett's hospitals and charities; Hospitals yearbook* (1934), 252-4; *Census, population abstracts, 1801*.

dation. There were nine institutions in the 30 towns with populations of between 9,000 and 15,000 (rankings 21-50) and seven, almost as many, in the next 30 towns, with populations of 6,000 to 9,000 (rankings 51-80). Of these smaller centres it was the old county and cathedral towns rather than the burgeoning industrial centres that were most likely to have a hospital. A good example is Winchester (1801 population 5,826, rank 89), site of the first provincial hospital, whose foundation in 1736 is attributed to the individual initiative of Alured Clarke, prebend of the Cathedral¹⁰³.

103 Woodward, *op. cit.*, p. 12.

Figure 3.8 Voluntary hospital beds per 1,000 population in British counties



How did this initially uneven distribution of voluntary hospitals develop subsequently? Figure 3.8 depicts the persistence of spatial variations, comparing the number of voluntary hospital beds per 1,000 people in the British counties for the years 1891 and 1931. It must be emphasised that this provides only a rough gauge to the geography of provision. Hospital catchments do not map neatly onto administrative units, and several, such as those in Bristol, Plymouth and Newcastle-upon-Tyne, straddled county borders. None the less a fairly clear pattern of regional distribution emerges, displaying features of continuity between the two periods surveyed. Well-provisioned areas included London, parts of south-west and south-east England and the Midlands; and in Scotland the urbanized central region around Glasgow and Edinburgh. The situation in the Highland counties is somewhat deceptive as this was a large, thinly populated area, but with a few well-provided hospitals in the towns. There is consistency too in the poorly provisioned areas like much of Wales, Cornwall, Lincolnshire and parts of Scotland, and also some of the Home Counties, perhaps because philanthropists living in London's hinterland concentrated their benevolence in the metropolis.

Table 3.2 shows that there were also marked variations in the county boroughs (large towns) of England and Wales. Here the numbers of voluntary hospital beds and inpatients per 1,000 people are used to indicate provision and utilisation rates. Towns in the upper and lower range are shown, ranked according to provision levels, for 1891, 1911 and 1938. Bed provision varied between the boroughs by a factor of about six or seven through the sequence, while the range of inpatient ratios remained substantial. The most favoured locations were the smaller, mostly long-established county and resort towns such as Canterbury, Chester, Bath, Bournemouth, Brighton, Exeter and Oxford, rather than the big industrial centres. Again the diffi-

Table 3.2 **Hospital provision and utilisation in county boroughs, 1891-1938, England and Wales**

Beds and inpatients per 1,000 people, upper and lower range

1891	Beds	Inpatients	1911	Beds	Inpatients	1938	Beds	Inpatients
Exeter	7.2	48.8	Bath	6.2	64.9	Oxford	7.2	108.8
Bath	6.1	55.0	Exeter	5.4	39.4	Canterbury	7.1	124.1
Gloucester	4.6	34.1	Oxford	4.3	59.1	Bath	6.4	91.2
Canterbury	4.6	33.5	Canterbury	3.7	37.6	Exeter	5.6	72.3
Chester	4.0	25.1	Gloucester	3.4	35.9	Northampton	5.1	76.5
Oxford	3.7	37.7	Chester	3.0	27.0	Chester	5.0	98.5
Wolverhampton	3.1	29.9	Worcester	2.9	26.5	Gloucester	4.6	74.6
Worcester	2.8	29.3	Wolverhampton	2.8	41.0	Norwich	3.9	73.8
Norwich	2.6	18.4	Bournemouth	2.6	25.7	Brighton	3.9	63.2
Bristol	2.6	30.1	Middlesbrough	2.6	26.2	Ipswich	3.7	69.2
Barrow-in-Furness	0.7	4.2	Grimsby	0.7	10.3	Salford	1.3	18.3
Salford	0.6	7.0	Rochdale	0.6	8.5	Rochdale	1.2	27.0
Oldham	0.6	5.4	South Shields	0.6	7.7	Tynemouth	1.2	24.9
Walsall	0.6	6.9	West Hartlepool	0.6	8.1	Portsmouth	1.2	26.7
St. Helens	0.5	3.6	Walsall	0.6	6.9	West Hartlepool	1.1	22.0
Croydon	0.5	4.9	Croydon	0.6	6.3	Stockport	1.1	25.3
Rochdale	0.4	3.0	Methyr Tydfil	0.6	6.8	West Ham	0.8	13.0
South Shields	0.3	2.4	West Ham	0.3	3.7	Croydon	0.8	12.9
Gateshead	0.0	0.0	Gateshead	0.3	3.6	East Ham	0.0	0.0
West Ham	0.0	0.0	Smethwick	0.0	0.0	Smethwick	0.0	0.0

Sources: Burdett's hospitals and charities; Hospitals yearbook; Census, population abstracts; National register, United Kingdom and Isle of Man, statistics of population, mid-1938 Registrar-General's estimates.

culty of mapping catchments onto administrative units must be stressed. Most boroughs at the very bottom of the range were suburbs of the largest centres, such as Croydon (London), St Helens (Liverpool), Smethwick (Birmingham), Gateshead and South Shields (Newcastle-upon-Tyne), where it is likely that proximity to other hospitals in the conurbation ameliorated the situation. Of the largest cities Liverpool, Manchester, Bristol and Newcastle were slightly above the national mean for bed provision (1938: 2.4 beds per 1,000 population) and Birmingham, Leeds and Sheffield slightly below. As in the industrial counties these cities tended to show above average inpatient rates, suggesting that heightened need exerted greater pressure on beds. Just above the lower range shown here were several boroughs set in a non-urban hinterland where provision and utilisation rates contrasted poorly with the top-ranked towns. These include Hull, Merthyr Tydfil, Warrington, Southampton, Southend-on-Sea, Coventry and Stoke-on-Trent, all of which were significantly below the national bed and inpatient means. Other centres started poorly provided but improved in the inter-war period, for example, Blackburn, Preston and Barrow-in-Furness.

Putting these figures into context requires comparison with municipal provision. On the eve of World War II the voluntary sector provided 95,000 non-psychiatric hospital beds in England and Wales, out of a total – including local authority and Poor Law hospitals – of 295,000 beds. Though the public sector was clearly dominant, this reflects its significance in providing long-stay hospitals and isolation facilities. Voluntary hospitals provided a majority of general hospital beds, however (70,000, compared to 60,000 in local authority hospitals) but the voluntary sector was, as we have indicated, unevenly distributed.

b. Hospital utilisation

The figures for utilisation given in the previous section may be overestimates, because they implicitly assume that all those treated in a given administrative area were residents of that jurisdiction. This takes no account of the complexity of flows of patients across administrative boundaries, but no previous analysis has been able to quantify the numbers of patients treated from each county and county borough in England, regardless of the location of the hospital that treated them. Here, we draw upon the Hospital Surveys undertaken during the Second World War by the Ministry of Health and the Nuffield Provincial Hospitals Trust to provide such an analysis¹⁰⁴.

The Hospital Surveyors requested from each hospital a geographical breakdown of the areas of residence of the inpatients they treated. This made possible the construction of a matrix of patient flows in which each cell gave the number of patients treated from area Y in hospitals in area X. Summing the row totals gave the total numbers treated from each area. Column totals gave the numbers treated at hospitals in each area. As an indication of the complexity involved, patients from the West Riding of Yorkshire were treated in over 40 separate counties or county boroughs. Of the 1,188,095 inpatients treated by voluntary hospitals in 1938, 94.2% were allocated to a county or

104 The problem of defining hospital catchment areas has been acknowledged, but not resolved, by previous commentators. See S. Cherry, 'The hospitals and population growth', *Population Studies* (1980), 34(1), 59-75. A more recent attempt to assess precisely which areas were served by individual hospitals in London is available but it involves a painstaking reconstruction from hospital admission and discharge registers, which could not easily be replicated for the whole country; G. Mooney, W. Luckin and A. Tanner, 'Patient pathways: solving the problem of institutional mortality in London during the later nineteenth century', *Social History of Medicine* (1999), 12(2), 227-69.

county borough¹⁰⁵. The remaining 5.8% were not evenly distributed, but this generally does not have significant effects on the analysis, with a small number of exceptions. The geographical origin of some 80% of patients treated in West Suffolk is not recorded, accounting for the relatively low utilisation rate there. In Birmingham, 7,951 of 34,857 (22.8%) voluntary hospital patients were recorded as 'not analysed', and the implication is that utilisation rates for this city, and for surrounding locations, are underestimates. With the exceptions of Herefordshire, Worcestershire and Lancashire, the proportions of patients classed as 'not analysed' do not otherwise exceed 10%. One option might have been to assume that all those in these 'not analysed' categories were residents of the area in which the hospital in question was located, but we have no real grounds for doing so. Note also that there are data missing for South Wales where the Surveyors did not obtain the detailed geographical breakdown of patient origins recorded for England. Although flows of patients from north to south Wales were probably small because of poor communications, we have nevertheless excluded Wales from this discussion¹⁰⁶.

The surveys allow calculations not only of the total numbers of inpatients treated in voluntary and municipal hospitals, but also of the total residents of an area receiving treatment in hospitals anywhere (the resident utilisation rate). Thus, for Lancashire, 18,918 patients were treated in voluntary hospitals in the county; if this were taken as a basis for calculating utilisation, the rate for Lancashire would be approximately 10 patients per 1,000 population. This figure refers to those treat-

105 Of those whose area of residence was not recorded, 569 came from 'abroad', 38,693 were 'not analysed' and 29,434 were classed as 'others'.

106 Further work is under way on these utilisation statistics; for details contact John Mohan.

ed in hospitals in the geographical county of Lancashire, excluding the county boroughs (i.e. large towns). Of those, 14,827 were residents of the county but another 27,270 Lancashire residents were treated elsewhere, giving a total of 42,097 inpatients and a utilisation rate for Lancashire's residents of 22.4 patients per 1,000 population. The relatively low proportion of Lancashire's patients treated within the county, exclusive of the boroughs, is partly an artefact of the number of county boroughs there, comprising urban centres with hospitals whose catchments extended over large areas. The discussion which follows relates to the resident utilisation rate (the total residents receiving treatment anywhere) in contrast to the hospital-based statistics given in the previous section.

The utilisation rate for voluntary hospitals overall in 1938 was 28 patients per 1,000 residents, but spatial variation is the hallmark of the pattern. Looking first at county boroughs, utilisation rates varied by a factor of over five. Table 3.3 presents the extreme values of the range. Large urban centres such as Birmingham, Newcastle, Stoke and Croydon feature in the bottom 10 county boroughs, though the figure for Birmingham is probably an underestimate because of the numbers of patients treated in Birmingham's voluntary hospitals whose geographical origin was not given. In addition to the bottom 10 county boroughs shown in Table 3.3, Nottingham, Plymouth, Hull and Manchester also had low utilisation rates which were only some 75% of the average for county boroughs of 28.4% patients per 1,000 population. At the other end of the spectrum the position of St. Helens and Tynemouth in the top 10 is surprising, as these boroughs had only limited local hospital provision. The appearance of prosperous southern boroughs (Oxford, Hastings, Bath, Gloucester, Bristol) in the top 10 is less surprising but there are some other boroughs there (Middlesbrough, Preston, Wallasey) which belie simplistic 'north-south' contrasts.

Table 3.3 Voluntary hospital utilisation rates for English county boroughs, 1938

<i>Top 10</i>	<i>Inpatients per 1,000 population</i>	<i>Bottom 10</i>	<i>Inpatients per 1,000 population</i>
Tynemouth	58.4	Birmingham	19.0
St. Helens	49.2	Newcastle-upon-Tyne	19.0
Hastings	44.3	Croydon	18.5
Middlesbrough	41.0	Stockport	18.5
Oxford	39.2	Carlisle	17.8
Gloucester	39.1	Salford	17.5
Bristol	38.8	Rotherham	16.5
Preston	38.3	Stoke-on-Trent	16.3
Bath	37.7	West Bromwich	11.8
Wallasey	36.9	Smethwick	11.3

Source: Ministry of Health and Nuffield Provincial Hospitals Trust (1945-6) *Hospital surveys*, 10 vols.

Note: Comparable data are not available for Wales or Scotland; the corresponding hospital surveys do not provide details on the area of residence of patients.

In addition to the boroughs listed, eight others (Bury, Eastbourne, Halifax, Southport, Brighton, Canterbury, Burton-upon-Trent and Barrow-in-Furness) recorded rates of over 33 patients per 1,000 population. A particularly notable feature of Table 3.3 is that the North East of England alone incorporates the full range of utilisation rates (Tynemouth and Newcastle-upon-Tyne). Comparison with Table 3.2, finally, offers a useful demonstration of our point about the limitations of attributing all the beds (or inpatients treated) in an area to the residents of that area because only Oxford, Bath and Gloucester feature in both 'top 10' lists, indicating the differential extent to which the

hospitals in these various boroughs drew patients from outside their jurisdictions.

Considering county councils (Table 3.4) there is not quite the same range: from 12.3 voluntary hospital inpatients per 1,000 population in West Suffolk to 39.2 in Rutland. There is a somewhat clearer geographical pattern here. There are 13 counties where utilisation rates exceeded 32 per 1,000 population. With the exception of Middlesex there is a contiguous belt of counties with high utilisation rates from Herefordshire to Kent (Figure 3.9). Conversely, low utilisation rates are typically found in rural areas with few large towns (even though we might ignore the low rate for West Suffolk because of the missing data there on patient origins). This indicates something about difficulties of gaining access to services. This is so not merely in the sense of travelling difficulties to urban services, which would be relevant in some of the low-ranking counties in the east and the north of England, but also in terms of referral networks.

This point is well illustrated if we return to the county boroughs (i.e. the large towns). Low levels of utilisation in Smethwick and West Bromwich, close to Birmingham, and in Rotherham, near Sheffield, might appear at first sight to be related to the presence of hospitals in the nearby cities, possibly discouraging the foundation of new institutions and perhaps prioritising requests for admission from the residents of these cities. But that would not explain the high utilisation rates for Wallasey and Tynemouth. Despite low levels of local voluntary provision, patients here appear to have had little difficulty in accessing hospital treatment in neighbouring cities. Clearly, local referral linkages must have played a part, such as the agreements made between hospitals and the workmen's contributory schemes in their region, which guaranteed access to the schemes' members. The relatively high utilisation rates for

Table 3.4 **Voluntary hospital utilisation rates for English counties, 1938**

<i>Top 10</i>	<i>Inpatients per 1,000 population</i>	<i>Bottom 10</i>	<i>Inpatients per 1,000 population</i>
Rutland	39.2	Lincolnshire – Kesteven	23.7
London	36.3	Middlesex	23.5
Gloucestershire	36.0	Peterborough	23.0
Wiltshire	35.2	Isle of Wight	22.6
Kent	35.1	Lancashire	22.4
Hertfordshire	34.4	Yorkshire – North Riding	22.3
Surrey	34.3	Huntingdonshire	21.8
Berkshire	34.3	Yorkshire – East Riding	21.6
Oxfordshire	34.2	Bedfordshire	14.5
Buckinghamshire	33.7	West Suffolk	12.3

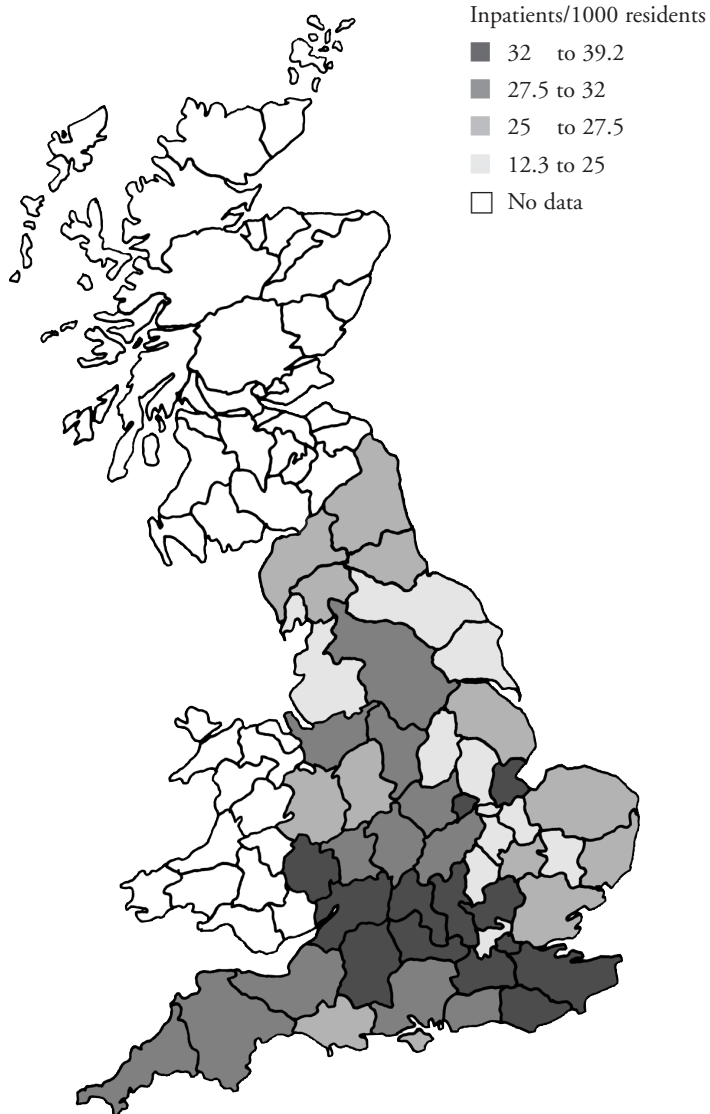
Source: Ministry of Health and Nuffield Provincial Hospitals Trust (1945-6) *Hospital surveys*, 10 vols.

most of the counties around London must also reflect ease of access to hospitals there. Thus, 50% of Middlesex residents treated as inpatients in voluntary hospitals attended hospitals in London, and the corresponding proportions for other counties around London were: Essex 34%, Hertfordshire 25%, Kent 27% and Surrey 32%.

To what extent did municipal provision compensate for inequalities in access to voluntary hospitals?¹⁰⁷ Municipal provision was very much the preserve of county boroughs rather than county councils, with the exception of the London County

¹⁰⁷ Technically these figures refer to numbers of patients treated in what the surveyors regarded as ‘general’ hospitals.

Figure 3.9 Voluntary hospital utilisation rates for English counties 1938



Council. Apart from London, there were only 11 county councils in which municipal hospital utilisation rates exceeded 10 per 1,000. Twenty-nine out of the 55 county councils had no municipal facilities for general hospital treatment. By contrast 58 out of 79 county boroughs provided municipal general hospital beds.

Focussing on the county boroughs (i.e. towns) alone, it can be argued that the growth after 1929 of publicly-funded municipal hospital provision played a key role in ameliorating variations in utilisation rates. We can demonstrate this statistically in two ways. Firstly, we use the coefficient of variation which divides a measure of dispersion in a set of values (the standard deviation) by the mean. This produces a result which is independent of the actual value of the mean. For the 79 county boroughs, the coefficient of variation of the voluntary hospital utilisation rates is 0.28 but is reduced to 0.22 for the total hospital utilisation rate (i.e. the voluntary and municipal hospital utilisation rates added together). A second way of expressing this is that for the county boroughs there is a strongly negative (-0.44) correlation coefficient between the municipal and voluntary hospital utilisation rates, which is, in a statistical sense, highly significant. The implication is that where access to voluntary hospitals was poor, local authority policies had some effect in improving access to services. Conversely, where access to voluntary hospitals was relatively good, local authorities were less active in providing services. Overall, it seems clear that local authority services reduced disparities in utilisation of services, though substantial variations remained.

c. Hospital waiting lists

This analysis of utilisation (need which was met) may be complemented with information on waiting lists (as an approximation for identified but so far unmet need), and again this highlights the uneven geography of the voluntary hospital. Data on waiting lists

should not be used uncritically, not least because they provide only a rough indicator of unmet need, a great deal of which may be manifested instead as emergencies, death or simply as reduced quality of life. What does a sizeable waiting list really indicate: lack of provision, or a successful hospital attracting patients due to the quality of facilities or the presence of medical staff of high repute¹⁰⁸? Furthermore, obtaining waiting list data is not easy. Prior to the Hospital Surveys there are no such data available nationally, although there were regional investigations, such as the reports produced for the Voluntary Hospitals (Onslow) Commission. This had been established in 1921 following the post-First World War hospital-funding crisis. In 1924 it was instructed to enquire into the adequacy or otherwise of existing hospital accommodation, and the resulting reports provide detailed information, though for a limited selection of counties¹⁰⁹.

The reports on Northumberland and Durham, for example, referred firstly to high levels of bed occupancy, exceeding 100% in Newcastle Royal Victoria Infirmary and 96-97% in Sunderland Royal Infirmary and Durham County Hospital as well as in smaller specialist institutions such as the Princess Mary Maternity Hospital in Newcastle. Waiting lists were also lengthy even allowing for the caveat that cases were only put on the list where there was some chance of admission¹¹⁰. On the basis of occupancy levels and waiting lists the reports suggested that no hospital in Northumberland or Durham could be considered to be under-occupied and that there was a clear need for additional accommodation.

108 Voluntary Hospitals Commission (1925) *Report* (Chairman: Lord Onslow), Cmnd. 1421, pp. 5-7.

109 *Ibid.*; Stone, *op. cit.*, pp. 56-7; B. Abel-Smith, *op. cit.* (1964), pp. 323-6.

110 PRO MH 58/173, 'Preliminary report, voluntary hospitals accommodation, Northumberland', March 1925.

Bed increases of up to 50% were required in Durham, for instance. In a reference to supply constraints the report argued that ‘the population of the North are not so inclined to seek treatment in voluntary hospitals as those further south This may be due to the impossibility of obtaining accommodation’¹¹¹. Equally, reference was made to the difficulty of obtaining the necessary finance to construct new hospitals or extend existing ones. It was therefore believed that, even allowing for the prospect of some assistance from public funds, there was limited likelihood that desirable extensions would be built. Much inter-war debate was silent on the question of just how gaps in the availability of services were to be closed.

The findings of the Onslow Commission are echoed in various reports of individual hospitals, which referred to places such as the North East as being ‘gravely underhospitalled’ and which suspected that needy patients often did not bother applying for admission¹¹². For more systematic statistics we refer to the data in the Hospital Surveys on waiting lists. Again, these statistics may not reveal much, given the variations between hospitals in the management of waiting lists, and the belief that patients were deterred from seeking admission. However, it is surely an indication of pressure on hospital accommodation that the waiting list in Newcastle was equivalent to 25% of patients treated in the city’s voluntaries; for Manchester the corresponding figure was 14% and for Birmingham 10%. None of these bore any comparison with Carlisle, where the waiting list was equivalent to 42% of the caseload of the city’s voluntary hospitals. This may be contrasted with the situation today, where nationally waiting lists for inpatients and day-cases stand

111 PRO MH 58/173, ‘Preliminary report, voluntary hospitals accommodation, Durham’, March 1925.

112 Royal Victoria Infirmary, Newcastle, *Annual report*, Tyne and Wear Archives, HO/RVI/72, 1919, see also, 1913, 1933.

at about 8% of annual hospital activity, although the context in which referral decisions are taken is now very different.

d. The relationship between provision and need

Does this analysis suggest that voluntary hospital provision tended to be greater in the wealthier areas, and less extensive in areas of the greatest need? Of course, 'need' is a slippery concept. Although early hospitals soon proved immensely popular they had not been founded in response to a pre-existing articulation of popular desire for institutional care. Instead the need for hospitals (what contemporaries called the 'hospital habit') had followed the spread of the institution. By the early 20th century normative expectations of provision had decisively shifted, reflecting public appreciation of the more specialised skills of hospital physicians and surgeons, the importance of easy access in accident and emergency cases, and of the technological facilities offered, like X-ray machines, operating theatres, and (in the 1930s) radium treatment for cancer¹¹³. In addition, need for hospital care, then as now, varied from place to place according to factors such as the occupational and age structure of the population. These in turn necessitate different responses from hospitals: a greater preponderance of geriatric beds in one place, more resources devoted to maternity care in another and so on. In the absence of reliable data on these factors the following statistical analysis of the relationship between provision and need is by necessity unsophisticated.

Broadly though, it does appear that those citizens in the greatest need were also those who in many cases had access to the lowest level of facilities – a situation sometimes dubbed the 'inverse care law'¹¹⁴. Where crude statistical correlations at local

113 Burdett's, *Hospitals and charities* (1901), xviii, 69; 1929.

114 J. Tudor Hart, 'The inverse care law', *Lancet* (1971), i, 405-12.

authority level between bed provision and need indicators have been attempted, they suggest that an inverse care law did indeed obtain before 1939¹¹⁵. Table 3.5 presents such calculations for English county boroughs for 1911 and 1938. The provision indicators used are hospital beds and their utilisation, and hospital expenditure, expressed in relation to the population of the county borough in which the hospital beds are located. For 1938 we also have the resident utilisation rates (for general hospitals) which we regard as a better measure of access to hospital treatment. In 1911, there are clear suggestions of an inverse care situation. The infant mortality rate is usually taken as a sensitive index of social conditions and all three provision indi-

Table 3.5 Correlation coefficients for need and provision indicators, English county boroughs, 1911 and 1938

<i>1911</i>			
<i>Need indicators</i>			
<i>Provision indicators</i>	<i>Crude death rate</i>	<i>Infant mortality rate</i>	<i>Rateable value (per capita)</i>
Voluntary beds/1,000 population	-0.210	-0.404**	0.149
Voluntary hospital expenditure/1,000 population	-0.287*	-0.455**	0.185
Voluntary hospital inpatients/1,000 population of borough in which hospital(s) located	-0.225	-0.355**	0.164

115 M. Powell, 'Hospital provision before the NHS: territorial justice or inverse care law?', *Journal of Social Policy* (1992) 21, 145-63.

Table 3.5 *continued*

1938			
<i>Need indicators</i>			
<i>Provision indicators</i>	<i>Crude death rate</i>	<i>Infant mortality rate</i>	<i>Rateable value (per capita)</i>
Voluntary beds/1,000 population	0.090	-0.267*	0.282*
Voluntary hospital expenditure/1,000 population	-0.050	-0.353**	0.200
Voluntary hospital inpatients/1,000 population of borough in which hospital(s) located	-0.170	-0.182	0.150
Resident-based voluntary hospital utilisation rate	0.180	-0.153	0.161
Resident-based municipal hospital utilisation rate	-0.002	0.446**	-0.140
Total resident-based (voluntary + municipal) hospital utilisation rate	0.130	0.367**	-0.030

Notes: **Statistically significant at the 1% level

*Statistically significant at the 5% level

Resident-based utilisation rates show the numbers of borough residents becoming hospital inpatients regardless of where the hospital is located.

cators are negatively correlated with it. These correlations are statistically highly significant: there is a probability of under 1% that they could be the result of chance. Correlations of provision indices with rateable values – the indicator of wealth – are in the expected direction (we would anticipate that provision

would be greater in the richer towns) but do not attain statistical significance.

The situation for 1938 is less clear-cut. Starting with the data based on the hospitals located in each area (i.e. the first three rows of the 1938 section of Table 3.5), there are negative correlations between infant mortality and hospital expenditure and bed provision, which are statistically significant (at the 1% level for expenditure and at the 5% level in the case of bed provision). Correlations with crude death rates are not significant, while for rateable values, which are an index of wealth, correlations indicate a positive association with provision, though this only attains statistical significance (at the 5% level) for bed provision.

It is clear that negative correlations between need and provision indicators declined between 1911 and 1938, this being particularly noticeable for associations with infant mortality. The implication is that the expansion of hospital capacity in the intervening three decades went some way towards closing gaps in the availability of services. When we consider the evidence for the contribution of municipal provision to the equity of the situation, it becomes clear that state action was central to improving access. Whereas the association between voluntary hospital utilisation and infant mortality is if anything negative (-0.153, but not statistically significantly different from zero), the corresponding correlation for municipal hospital utilisation is positive (+0.446) and significant at the 1% level which strongly suggests that municipal services were most developed in areas of greatest need. With respect to overall utilisation, it seems that the effect of public provision was to achieve greater equity in access to resources: there is a positive correlation (significant at the 5% level) between total utilisation and infant mortality.

These figures of course indicate association, not causality, but the general inference to be drawn is that the pre-NHS vol-

untary hospital system was far from equitable and that municipal action was needed to compensate.

These statistical conclusions are supported by closer inspection of the data. The well-provided boroughs (Tables 3.2, 3.3) were often comfortable county and university towns and seaside resorts containing relatively large proportions of wealthy retired people. In addition, the residential preferences of doctors tended to be determined by calculation of where the potential rewards from private practice were likely to be greatest; hence specialists were also more concentrated in this type of location, along with towns in which medical schools were situated¹¹⁶. Contrast such towns with, for example, Merthyr Tydfil in South Wales, which in the 1930s experienced the full force of the economic depression and where the effect of poverty was reflected in worsening morbidity rates. This was one of the most underbedded towns, whose hospital was staffed principally by local GPs, and where patients requiring specialists for quite routine matters were forced to travel to Cardiff¹¹⁷.

Other sources relating to the poorer parts of the country back up these assessments. A series of national surveys undertaken by the Ministry of Health is replete with observations on deficiencies in the quality and quantity of services available in many areas¹¹⁸. Investigations in the 'Special Areas' (the derelict

116 A. Digby, *Making a medical living: doctors and patients in the English market for medicine, 1720-1911* (Cambridge, 1994), pp. 20-3; M. Gorsky, J. Mohan and M. Powell, 'British voluntary hospitals 1871-1938: the geography of provision and utilisation', *Journal of Historical Geography* (1999) 25, 463-82.

117 Dr Wade, *Merthyr Tydfil County Borough Survey*, 1931, PRO MH 96/383, pp. 4, 36, 54, 56, 59, 64.

118 These surveys were conducted after the 1929 Local Government Act in order to identify gaps and also to assess the vigour with which local authorities were discharging their responsibilities. The reports and subsequent correspondence are held at the PRO, reference MH 66.

coalfields of South Wales, Scotland, Cumberland and the North East) amply document the impact of depression on hospital finance and provision¹¹⁹. These disparities in levels of provision were compounded by poor-quality services, evidenced in the lack of resident medical staff, the absence of operating theatres, and deficiencies in equipment¹²⁰.

These disparities in provision hardly went unnoticed by contemporaries. From the 1860s public alarm had been raised at the situation in London, where hospital accommodation was concentrated in the centre and West End, while the populous East End and south of the city were seriously under-bedded. In 1902 the King's Fund, which had been established as a central agency to rationalise voluntary fund-raising in the capital, began to target its gifts so as to provide incentives for relocation to these areas¹²¹. Despite this, the persistence into the 1930s of substantial variations in provision was used by the London County Council to justify its policy of opening rate-funded municipal general hospitals to deliver acute care. By the late-1930s and early 1940s the notion that regional diversity was a weakness of voluntarism to be addressed by planning had

119 J. Mohan, 'Neglected roots of regionalism? The Commissioners for the Special Areas and grants to hospital services in England', *Social History of Medicine* (1997), 10(2), 243-262.

120 For example, a 1937 survey by the Ministry reported that 255 out of 966 (26.4%) voluntary hospitals lacked an operating theatre: these were characteristically smaller institutions of a cottage hospital type, with an average size of 45 beds. However, the proportion of such institutions varied between regions, reaching 33% in Northumberland, Cumberland and Durham. Thus the mere presence of a hospital did not guarantee good-quality facilities. See PRO MH 55/16 for the survey referred to here. Much fuller comments on the quality of hospital accommodation are provided in the wartime surveys.

121 G. Rivett, *The development of the London hospital system, 1823-1982* (London, 1986), pp. 94-102, 124-5, 134, 161-70; F. Prochaska, *Philanthropy and the hospitals of London* (Oxford, 1992), pp. 66-70.

gained broad acceptance, as evidenced by the influential ‘PEP’ Report on the British Health Services and by wartime hospital surveys carried out by the Ministry of Health¹²². When presenting the NHS Bill to the House of Commons Aneurin Bevan noted that owing to the ‘caprice of charity’ the best endowed areas were those ‘where the well-to-do live while, in very many other of our industrial and rural districts there is inadequate hospital accommodation’¹²³.

This is not to suggest that state agency immediately rectified the situation. Disparities in the capital stock began to be addressed only with the 1962 Hospital Plan, which also made some progress towards convergence in bed/population ratios¹²⁴. The Resource Allocation Working Party (RAWP) in the mid-1970s developed more sophisticated procedures, which were applied from 1976-91, to address divergence in health authority revenue budgets¹²⁵. Although important intra-regional disparities remained, public provision is generally considered to have begun to address successfully the legacy of voluntarism – as the RAWP described it: ‘the inertia built into the system by history’¹²⁶.

In sum, there were several aspects of the voluntary hospital system which tended towards uneven provision. These included the constellation of local factors and individual impulses which determined the timing and scale of foundations and

122 PEP, *op. cit.*, pp. 256-62.

123 HC Deb., 5th series, v. 422, c. 46-7.

124 Ministry of Health, *A hospital plan for England and Wales* (London, 1962), Cmnd. 1604.

125 Department of Health and Social Security (DHSS), *Report of the Resource Allocation Working Party* (London, 1976).

126 Department of Health and Social Security (DHSS), *op. cit.*, p. 7; N. Mays and G. Bevan, *Resource allocation in the health service* (London, 1987); C. Donaldson and K. Gerard, *The economics of health care financing* (Basingstoke, 1993) p. 161.

extensions, the residential and career choices of doctors, the underlying wealth of an area, and the density of middle-class residents who might support medical charity. Therefore, long before the 'postcode rationing' identified with the NHS, access to quality care was shaped by residence. To return to Seldon's view, quoted earlier, the 'galloping horse' of voluntarism had most certainly not found its way into every part of the country, and regional disparities remained an important spur to reform.

Box 3.2 Voluntary hospital provision and use

- Voluntary hospitals were unevenly distributed around the country. Provision was not matched with need.
- In 1938 numbers of voluntary hospital beds per 1,000 population were still highest in smaller, long-established county and resort towns and lowest in the suburbs of large cities.
- At that time, the voluntary sector provided 95,000 non-psychiatric hospital beds in England and Wales.
- Local authority and Poor Law hospitals provided another 200,000 but many of these were long-stay and isolation hospital beds.
- Voluntary hospitals provided 70,000 general hospital beds and local authority hospitals 60,000 in 1938.
- Voluntary hospital utilisation rates in 1938 varied from 11.3 inpatients per 1,000 beds in Smethwick to 58.4 in Tynemouth.
- Inter-war growth in publicly funded municipal hospital provision played a key role in evening out utilisation rates geographically. But substantial variations remained.
- Broadly speaking, an 'inverse care law' prevailed before 1939: hospital provision and utilisation were often lowest in the poorest, most needy areas.

3.4 Accountability and local democracy

The late 18th century, when the voluntary hospitals first emerged, is now characterised by historians as the period in which civil society flourished as never before. A ‘public sphere’ developed, distinct from the activities and organisations of the state and the market. Its key feature was the efflorescence of charitable, educational and cultural institutions which rapidly became a ubiquitous feature of urban living. Unlike the closed vestries and corporations of unreformed Britain their membership was open to all, and principles of transparency and accountability were fundamental to their procedures¹²⁷.

The early voluntary hospitals epitomised these aspects of this new associationalism, and in some respects may be seen as beacons of citizen participation. Public accountability was ensured through the printed annual report, which contained audited accounts, patient statistics, current rules and even the names and contribution of each subscriber, all of which was available to the local press. Payment of an annual subscription entitled donors to exercise various managerial prerogatives. These included the right to admit patients and to vote at general meetings held at least once a year. In the early 19th century the subscribers’ franchise could also extend to the election of the medical staff, obliging doctors seeking honorary posts to canvas publicly on behalf of their candidacies. Subscribers also elected from amongst their number the volunteer members of the committees which oversaw day to day management of the hospital, and the hospital ‘visitors’ who offered pastoral care to patients.

Of course, while participation was technically open to all, it was far from universal. Many donors were disinclined to involve themselves in hospital affairs, while the majority of the

127 R. Morris, ‘Civil society and the nature of urbanism: Britain 1750-1850’, *Urban History* (1998) 25, 289-301.

population was debarred by the inability to contribute. With early 19th century subscription rates typically set at one guinea (£1.05), when the wages of unskilled labour stood at around 10 shillings (£0.50) per week, lay administration was effectively limited to the middle class. Civil society, 'in truth...was never a comfortable reality, except for the few'¹²⁸.

By the early 20th century the administrative role of the voluntary subscriber was significantly reduced. Middle-class enthusiasm for involvement in local hospital affairs did not grow at the same rate as the middle class itself. A significant 'free rider' effect was discernible, as many citizens who could afford to subscribe did not and allowed their more public-spirited neighbours to shoulder the burden. In Bristol for example the number of private subscribers to the two main voluntary hospitals stood at about 6,000 people in 1931, in a city of 400,000; Newcastle's Royal Victoria Infirmary had only 400 charitable subscribers from a conurbation of one million people! Some major hospitals had relinquished the system of subscribers' admission tickets by the 1890s in favour of open access, limited only by the size of the waiting list and medical assessment of urgency¹²⁹. Others maintained the ticketing system into the 1930s, fearing that its abandonment would further discourage the charitable. In practice subscriber admissions enjoyed no priority over others, although charity patients were excused pressure from the almoner to contribute.

As the involvement of the lay volunteers waned the power of the medical men was waxing. Expanding accommodation gave doctors greater discretion to admit non-emergency patients with-

128 M. Walzer, 'The civil society argument', in C. Mouffe (ed.) *Dimensions of radical democracy: pluralism, citizenship, community* (London, 1992), pp. 89-107.

129 G. Haliburton Hume, *The history of the Newcastle Infirmary* (Newcastle-upon-Tyne, 1906) pp. 84-7.

out a subscriber's letter, and in some hospitals the balance tilted rapidly from predominantly charitable to predominantly medical admissions¹³⁰. This process was hastened by the growing assertiveness of honorary medical staff who, though motivated by goodwill, also viewed the hospital as a place of research, teaching and scientific expertise. Direct election of consultants was abandoned by the late 19th century in favour of selection by an appointments committee. In large hospitals medical committees were constituted to act as a forum for the development of the medical policy and to articulate doctors' needs to the lay governors. Thus despite some notorious clashes between medical representatives and voluntary administrators, such as the dispute over the reform of nursing practices at Guy's Hospital in 1879-80, the managerial role of doctors was generally enhanced¹³¹. Even so, new strains arose in the inter-war period of the 20th century, when voluntary trustees sometimes blocked the efforts of university medical schools to forge closer links with hospitals, on the grounds that the standard of personal care might suffer if patients were treated primarily as objects of research¹³².

If the decline of subscriber power did not entirely inhibit lay voluntary control, did the growth of workplace contribution broaden public participation? In financial terms the dwindling of private subscription was amply compensated by the sums which mass contributory schemes generated. Workmen's subscriptions had first emerged in the 1850s and by 1900 had been formalised both in the Hospital Saturday Fund (an annual neighbourhood and workplace collection targeting small

130 Fissell, *op. cit.*, pp. 110-47.

131 K. Waddington, 'The nursing dispute at Guy's Hospital, 1879-80', *Social History of Medicine* (1995), 8, 211-30; see also *Burdett's hospitals and charities* (1901), pp. 69-74.

132 Bristol General Hospital, *Board minutes*, 14.6.20, Bristol Record Office 40530/A/1/a/3.

donors) and in the development of formal schemes in which workers regularly gave a fixed sum from their pay. Large-scale heavy industry nurtured this type of arrangement: coal, ship-building and munitions in the North East, for instance. The inter-war period witnessed dramatic expansion. The Cave Committee report of 1921 (a government inquiry into hospital finance)¹³³ had advocated mass contribution as a solution to post-war funding shortfalls and many hospitals independently established local schemes as a solution to funding difficulties¹³⁴. Some regarded the income raised as a quasi-charitable voluntary gift, while others treated it as a form of low-cost insurance, with payment formally entitling those covered to remission of charges. The upshot of all this was that the numbers of voluntary hospital contributors vastly increased. In Newcastle's Royal Victoria Infirmary for instance, over 50,000 belonged to the scheme in 1938, providing 58% of total income¹³⁵.

To some extent this expansion of contribution reinvigorated popular participation in hospital affairs. The constitution of management committees was gradually changed to accommodate representatives of the schemes, though even in hospitals where mass contribution was a vital income source the numbers of such representatives remained a minority. Pursuing the Newcastle example, of the Royal Victoria Infirmary's 44 committee members in 1901 only 12 were nominated by the workmen governors, and this minority persisted into the inter-war period¹³⁶. Despite this, there is no doubt that contribution strengthened ties of loyalty and support from workers for 'their'

133 Voluntary Hospitals Committee (Chairman: Lord Cave), *Final report* (London, 1921), Cmnd. 1335, p. 19.

134 Stone, *op. cit.*, pp.46, 221.

135 *Hospitals yearbook*, 1939; Royal Victoria Infirmary, *Annual report*, 1938, pp. 100-26.

136 Royal Victoria Infirmary *Annual report*, 1901.

hospital. This might take the form of the purchase of essential equipment, the endowment of a bed, the organisation of fundraising activities and gifts 'in kind', such as clothes made by sewing clubs.

However, this does not necessarily signify a blossoming of grassroots associative democracy. Working-class contributors who sought greater voice in hospital government could be frustrated, as the case of Sunderland Royal Infirmary in the 1930s demonstrates. Here the workmen representatives on the Court of Governors persistently clashed with the charitable subscribers and the honorary staff, who outnumbered them by two to one. First they objected, unsuccessfully, to proposals to open wards for fee-paying patients on the grounds that the hospital's prime duty was to the poor. Next they sought to dismiss a doctor who had made himself unpopular with miners through his treatment of industrial injury claims. Outvoted again, they then sought to increase their representation to better reflect their financial contribution: about 22,000 scheme members provided 52% of income in 1937. Again they failed, cautioned by the Chairman that their job was to 'do their best for the Infirmary and not simply to represent a sectional interest'¹³⁷.

In summary, although there were elements of openness, subscriber democracy and accountability in voluntary hospitals from their inception, participation was initially limited to middle-class contributors. The role of private subscribers subsequently diminished and the decision-making roles of medical professionals and lay governing bodies were enhanced. The transition to mass contribution strengthened popular support for the institutions. However, management remained in the hands of traditional elites who were reluctant to adopt constitu-

137 Sunderland Royal Infirmary, *Annual reports, 1935-7*, Tyne and Wear Archives, 1381/111-2.

tions which radically enhanced democratic participation. We may conclude with Bevan's experience, as described in the second reading of the NHS Bill: 'In the mining districts, in the textile districts, in the districts where there are heavy industries it is the industrial population who pay the weekly contributions.... When I was a miner I used to find that situation when I was on the hospital committee. We had an annual meeting and a cordial vote of thanks was passed to the manager of the colliery company for his generosity towards the hospital; and when I looked at the balance sheet I saw that 97.5% of the revenues were provided by the miners' own contributions; but nobody passed a vote of thanks to the miners'¹³⁸.

3.5 Co-ordination and planning

Historians of the coming of the NHS have observed the emerging consensus in the 1930s and 1940s within government circles and the medical profession in favour of greater co-ordination of health services¹³⁹. The challenge for policy makers and hospital managers in inter-war Britain was to secure some of the benefits of an integrated system through a partnership of public and non-profit providers. Despite these intentions, the Nuffield Hospital Surveys pronounced in 1946 that 'there is no hospital system now' and condemned 'the results of unco-ordinated development in the past'¹⁴⁰. Can the voluntary hospitals be justly criticised for failing to build structures conducive to local and regional co-operation?

138 *HC Deb.*, 5th Series, v. 422, c. 47.

139 D. Fox, *Health policies, health politics: the British and American experience, 1911-65* (Princeton, 1986) p. ix; R. Klein, *The politics of the NHS* (London, 1989), pp. 2-7; H. Eckstein, *The English health service: its origins, structure and achievements* (Cambridge, 1988) pp. 101-32.

140 Nuffield Provincial Hospitals Trust, *The hospital surveys: the Domesday Book of the hospital services* (Oxford, 1946) p. 4.

The 1920s began with a clear articulation of the need for a more coherent system, built around joint committees representing voluntary hospital leaders and public officials. The benefits envisaged were cost savings through joint purchasing, co-ordination of fund-raising, the elimination of competition and duplication of services, a planned provision of accommodation, and improvement of research and teaching. The Cave Committee arranged for the formation of local joint committees as a prerequisite for distributions of Exchequer grants¹⁴¹. At the same time the newly formed Ministry of Health advocated closer links between amalgamated groups of voluntary hospitals and university medical schools, whose full-time staff would take over clinical teaching¹⁴². In a few localities joint planning between the local authority, the voluntary sector and private practitioners was enthusiastically developed. For example, the Gloucestershire Extension of Medical Services Scheme used public funds to contract services for thinly populated rural areas. 'Out-stations' staffed by GPs were opened in such areas of the county, and patients were referred to consultants in the voluntary hospitals for specialist services¹⁴³. In Aberdeen plans were made for public and charitable funds to combine in the relocation of the voluntary and public hospitals and the university medical school to a dedicated greenfield site¹⁴⁴. A more ubiquitous, and more modest, force for cohesion was the embryonic hospital social work carried out by almoners, whose

141 Voluntary Hospitals Committee, *op. cit.*

142 Stone, *op. cit.*, pp. 49-52; S. Sturdy, 'From Hippocrates to state medicine: George Newman on the early policy of the Ministry of Health', in C. Lawrence and G. Weisz (eds.) *Greater than the parts: holism in inter-war medicine*, (1998).

143 Gloucestershire Record Office, 'Extension of medical services: Board of Management minute book', CM/M/16/1.

144 Logie, *op. cit.*

remit included arranging aftercare of patients in convalescent homes and liaison with other public and voluntary agencies.

However, the promise of this period went unfulfilled. The joint committees recommended by Cave fell into abeyance once the grants were distributed and although there were calls for statutory regional bodies and a permanent government grant, from the Scottish Board of Health for example, these were rebuffed¹⁴⁵. Despite much publicity the Gloucestershire Scheme was not copied elsewhere, and county council spending restraints meant that its scope was rapidly curtailed¹⁴⁶. In Aberdeen the slow pace of fund-raising for the joint scheme led to the withdrawal of the council, in favour of developing a municipal hospital¹⁴⁷. Voluntary hospital coordination could still occur, as in Birmingham where strong political leadership encouraged their amalgamation and relocation alongside the medical school¹⁴⁸. Elsewhere the tradition of local pride and competition for funds hindered such moves. In Bristol for example, despite the enthusiasm of many consultants for the merger of the city's two teaching hospitals, amalgamation was delayed until 1937, when the financial crisis of the General Hospital made it inevitable¹⁴⁹.

The Local Government Act of 1929 embodied a more determined attempt to promote coordination – all the more necessary now that rate-financed municipal general hospitals were emerging to rival the voluntaries. Section 13 of the Act provided for

145 Stone, *op. cit.*, p. 52; Scottish Board of Health, 'Ministry of Health: Voluntary Hospitals Commission', SRO HH 65/49; Hospital Services (Scotland) Committee, SRO HH 65/51.

146 Gloucestershire Record Office, *op. cit.*

147 Logie, *op. cit.*, pp. 166-8.

148 Chamberlain papers, University of Birmingham, NC 5/8/1/20, 21, 49.

149 M. Gorsky, 'The transformation of Bristol's hospital service, 1918-48', in P. Wardley (ed.) *Bristol: historical resource*, (CD-ROM, University of the West of England, Bristol, 2000).

the establishment of joint public/voluntary committees which would organise the respective contributions of the two sectors. Six years later the Ministry of Health surveyed the progress of this measure, and discovered that while joint committees had been established in 43 out of 78 English boroughs, 23 had made no formal arrangements and 12 had taken no action at all. In some places the social and ideological gulf between proponents of municipalism and voluntarism hindered progress. In Blackburn, for example, the chair of the council's Health Committee '...had queered the pitch ... by a very unwise handling of the meeting, gratuitously casting aspersions on the good faith and public spirit of the hospital representatives, so that relations had cooled'¹⁵⁰. In London, where formal arrangements had been rapidly put in place, the antipathy between municipal socialists on the London County Council and aristocratic voluntary hospital patrons had fostered a state of 'cold war' in which genuine co-operation remained limited¹⁵¹.

Progress towards joint working in the 1930s was more successful in large provincial cities containing teaching hospitals, such as Manchester, Sheffield, Birmingham, Liverpool and Aberdeen. Here the voluntaries had already begun to work together, and so had a representative mechanism in place which could establish formal links with the council. Relocation could be a key factor, as in Aberdeen, where the town council financed the antenatal department of the Maternity Hospital and co-managed the pathology laboratory when the new site eventually developed¹⁵².

The concern of university medical schools to shape institutional arrangements to the needs of teaching was also crucial.

150 PRO MH 66/1067, *Blackburn: public health survey*, pp. 33-4.

151 J. Pater, *The making of the NHS* (London, 1982), p. 16; Rivett, *op. cit.*, pp. 205-6; Prochaska, *op. cit.*, p. 114.

152 Logie, *op. cit.*, pp. 171-6.

Their agenda was to establish teaching posts and access to cases in municipal hospitals, and they used their position on joint boards to organise appointments and rationalise services to further specialisation and the delivery of scientific expertise¹⁵³. In Manchester for example, the joint board foreshadowed the activities and strategies of the area's Regional Hospital Board under the NHS¹⁵⁴. Joint hospital boards could also flourish in bastions of voluntarism, such as Oxford, where the generously endowed Radcliffe Infirmary carried out much of the work undertaken by public institutions elsewhere. Here, the Radcliffe's leadership concluded that the progress of municipal hospitals signalled the imminent collapse of voluntary funding. If the benefits of voluntarism were to be preserved, particularly independent teaching and research, then 'whole-hearted co-operation' was the best strategy¹⁵⁵. The President of the Board was Oxford philanthropist William Morris, Lord Nuffield, and a similar goal of heading off state intervention through joint public/voluntary regional structures informed the work of the Nuffield Trust, which he established at the same time.

Another force for integration was the broadening coverage of the mass contributory schemes. The original principle of restricting treatment of contributors to a single hospital soon proved inadequate: what if specialist treatment was needed, or a patient fell sick away from home, or was moved to a public hospital or a convalescent home? Mutual agreements to treat members of other schemes were therefore made between public and voluntary hospitals, and between large and small voluntaries¹⁵⁶.

153 J. Pickstone, *Medicine and industrial society* (Manchester, 1985), pp. 272-93.

154 *Ibid.*, pp. 272, 292-3.

155 Radcliffe Infirmary, *Annual report*, 1937.

156 S. Cherry, 'Beyond National Health Insurance', pp. 473-5.

This in turn created pressure for more standardisation of contribution and benefit levels from place to place.

To summarise, despite government encouragement and some promising initiatives, the 1920s saw only faltering progress towards joint arrangements, either within the voluntary sector or between public and voluntary providers. The requirement for consultation contained in the 1929 Local Government Act gave an impetus for change, and joint authorities made some progress, especially in towns where university medical schools worked with progressive municipal authorities. But despite this and other grassroots initiatives, the Nuffield Trust was correct to observe that nationally there was still no 'hospital system' by 1938. Mutual suspicion, based on ideological distrust and social differences, coupled with institutional stasis and a habit of independence, were powerful forces inhibiting change. Public/third sector co-operation might have been more actively enforced by the state, but the traditionally permissive approach to local government legislation prevented this.

3.6 Conclusion

The developments outlined in this chapter do not show an 'inevitable' passage towards the welfare state, not least because the Second World War was also crucial, both in establishing the framework for state supervision and in further demoralising the voluntaries through the destruction suffered in the Blitz¹⁵⁷. Instead the purpose of this retrospect has been to appraise the performance of the voluntary hospitals in the final phase of their independent existence. This was the period in which the difficulty of financing a mass hospital service from voluntary sources became apparent, and despite income diversification

157 Prochaska, *op. cit.*, p. 138.

many institutions could not comfortably meet expenditure demands. From the mid-1930s annual deficits were becoming more common, with some large hospitals exhausting their capital reserves and becoming reliant upon borrowing. The problem of rising debt became more acute as publicly funded municipal hospitals undermined philanthropy. Financial salvation came from mass contribution, but this broadening of entitlement was not accompanied by the sort of radical overhaul of hospital governance which might have provided a bulwark for the voluntary system. Meanwhile the state sought to preserve the voluntary principle through public/non-profit partnership, but the legacy of uneven provision, coupled with rivalry and a residual mistrust impeded the emergence of a new system based upon joint working. This was the context in which arguments in favour of nationalisation became compelling.

4 THE REVIVAL OF CHARITABLE FUNDRAISING IN THE CONTEMPORARY NHS

In one sense it might appear illegitimate to draw parallels between contemporary charity in the NHS and the pre-NHS situation. All the major hospitals are in public ownership and by far the largest part of funding is derived from taxation. However, it can be argued that the recent growth of charity raises several of the key issues which would have been familiar to observers of the pre-NHS era, and which were familiar criticisms of that system of delivering health care.

We begin by briefly reviewing the position of charity under the NHS up to 1980, examining the fate of the existing endowments which the state inherited, and then identifying the approach subsequently taken to charitable fund-raising. Building on earlier studies¹⁵⁸ we concentrate on three issues: the growth of appeals for charitable support for the NHS; capital appeals for funds for the reconstruction or expansion of NHS hospitals; and proposals to return (at least some) public hospitals to charitable ownership. In considering parallels with the pre-NHS era, we discuss our four key themes of equity, financial stability, accountability and planning.

4.1 Charity under the NHS: a new role emerges

Charitable sources of funding for health care did not disappear following the establishment of the NHS¹⁵⁹. Despite nationalisation, charitable effort was not prohibited, but it was anticipated that its future role would be confined largely to providing

158 L. Fitzherbert, *Charity and the national health* (London, 1989); M. Lattimer and K. Holly, *Charity and NHS reform* (London, 1992); M. Lattimer, *The gift of health* (London, 1996).

159 I. Williams, *The alms trade* (London, 1989).

comforts for patients and staff, funded by small tokens of appreciation, refusal of which would be churlish. There was also the question of the status to be accorded to past charitable gifts. In England and Wales endowments of hospitals were either transferred to the Boards of Governors (in the case of teaching hospitals) or to a new National Hospitals Endowment Fund. An Endowment Commission was set up which typically distributed small sums to each Hospital Management Committee in England and Wales in proportion to the number of beds for which they were responsible.

A similar organisation existed in Scotland and a brief study of its activities will usefully illustrate the reorientation of the state's approach to charity in the decade following the creation of the NHS¹⁶⁰. The Scottish Hospitals Endowment Commission was appointed in 1949 to oversee the allocation and future use of the charitable endowments held by individual hospitals. It had a more difficult task than its English counterpart because the Scottish legislation had not permitted the teaching hospitals to retain their trusts. Nor had the legislation laid down any general principles of redistribution, so the fate of almost half a million pounds was left to the Commission's discretion¹⁶¹. Under the chairmanship of Sir Sydney Smith, Dean of Edinburgh University Faculty of Medicine, it began by consulting the five Scottish Regional Health Boards (RHBs) and the Boards of Management of the 85 separate hospital groups, to establish the extent of the holdings and solicit opinions on their future application. Once the returns from the boards were assembled they revealed a picture of considerable regional variation in endowed wealth. The Northern Region held funds

160 The Commission's minutes and papers are held in the Scottish Record Office, Edinburgh, reference HH96/1 and HH96/2.

161 SRO HH96/2, (49) 2, 'Memorandum from Secretary of State'.

with a mean value of only £97 per bed, against £287 per bed in the South East, and these differences were more pronounced at the level of the hospital groups, 23 of which had either negligible endowment capital or none at all¹⁶². Unsurprisingly, the better off boards also favoured retaining control of their funds.

The Commission began by setting out principles for future expenditure. Now that the Exchequer had taken full responsibility for the provision of hospital services, some 40% of the endowments were to support research, and the remainder to provide amenities for staff and patients. These were defined as items falling outside the ambit of 'curative purposes', such as entertainments, leisure and recreation facilities, furnishings and so on¹⁶³. It then resolved on a partial redistribution, which would guarantee each hospital Board of Management a minimum £2 per bed for amenities. Reallocations from well-endowed boards were generally confined to adjacent or nearby boards within a given region, although the Northern region benefited at the expense of the rest¹⁶⁴. After some debate it was agreed that research funds would not be held by the Regional Health Boards, but would be overseen by a central body which would distribute them according to nationally agreed priorities¹⁶⁵.

Three important pointers to the role of charity under the NHS can be derived from this process. First the state did not impose a bureaucratic solution, but sought instead to shape policy around the wishes of 'civil society', arrived at by the expert-

162 SRO HH96/2 (50) 2, 'Provisional figures'.

163 SRO HH96/2, (50) 4, 'Notes on amenities'; SRO HH96/1, Minutes, 17 October 1950.

164 Department of Health for Scotland, *Hospital endowments: report of the Hospital Endowments Commission*, HMSO (Edinburgh, 1955), pp. 8-12.

165 This was established by the Hospital Endowments (Scotland) Act, 1953, see SRO HH96/2 (54) 3, 'Note'.

ise of the commissioners and an open consultation process. The Commission was thus able to assert with some justification that a ‘spirit of friendly co-operation’ had prevailed, with richer Boards eventually accepting the obligation of redistribution to the less well off¹⁶⁶. Second, it was firmly established in principle that the commitment to Exchequer funding under the 1948 NHS Act entitled the state to override the original terms of charitable trusts. Where hospital representatives objected to the Commission’s neglect of ‘the spirit of the intention of the founders of the endowments’, they were given short shrift¹⁶⁷. But third, despite this extensive power, the redistribution was only partial because the state did not wish to deter future charity. The minimal figure used as the basis for reallocation meant that rich Boards retained much of their wealth, and nationally only around 40% of endowments were transferred. The regional basis of the distribution also recognised the historical geography of earlier benevolence. The Commission was explicit in its hope that the exercise would in due course encourage ‘new donations and bequests’¹⁶⁸. In the conclusion to this paper we return to the theme of how the state might manage charitable funds.

While the Endowment Commissions were charged with administering existing voluntary funds, some institutions felt that they should be permitted to continue to raise money through new charitable appeals. While many hospitals made representations to this effect, they were not granted permission to do so. Aneurin Bevan, wanted to encourage ‘all the voluntary help we can get’¹⁶⁹, though it is clear from the context that

166 *Hospital endowments*, p.4.

167 SRO HH96/1, Minutes, 23 June 1954.

168 *Hospital endowments*, pp.8-9, 12.

169 PRO MH 99/43, Bevan-Eastwood, 24/04/49.

he was referring to voluntary labour rather than voluntary fundraising. But Ministry policy was against local fundraising on the grounds that it would highlight inadequacies in funding and complicate the task of planning¹⁷⁰.

The 1956 Guillebaud Report¹⁷¹ pointed out the role of charitable fundraising in stimulating local support for hospitals, but also recognised the potential ‘embarrassment’ that could be caused: hospitals clearly had great pulling power but there were other statutory services where needs were just as great¹⁷². It was tacitly acknowledged that charitable funds were ‘not infrequently used for purposes for which Exchequer money would have to be found sooner or later. We are not anxious to advertise this fact’¹⁷³, as to do so would cause voluntary contributions to dry up.

Although Conservative Ministers, such as Iain Macleod, relaxed some restrictions on appeals, an uneasy compromise held: statutory authorities could not appeal for funds directly and charitable money could not be used to fund ‘core’ services that the Exchequer was expected to finance. This policy did not, of course, preclude health authorities from developing valuable relationships with voluntary agencies, such as Leagues of Friends, through which useful amenities and services were provided. This policy held until 1980 when the Conservatives sought, through the Health Services Act, to permit health authorities to engage in a range of fundraising activities. Our discussion now concentrates on the growth in charitable support for the NHS especially since this Act.

170 MH 99/37, ‘Appeals for funds by hospital authorities’, no date, but probably 1957.

171 Guillebaud Committee, *Report of the Committee on the Cost of the NHS*, HMSO, Cmnd 9663, 1956.

172 *Ibid.*, para. 381.

173 PRO MH 99/37, Alexander to Nixon Browne, 12/02/57.

4.2 Trust fund income and charitable fundraising

The Health Services Act of 1980 introduced two major innovations: health authorities could organise their own charitable appeals; and they were empowered to use Exchequer funds to pay for the costs of launching appeals, these costs to be repaid from the proceeds of the appeals. This Act remains the only direct piece of legislation explicitly designed to expand the scope of charitable fundraising activity by health authorities.

The 1948 Act was presented to parliament as a ‘modest extension of the existing powers’ of health authorities. Patrick Jenkin (the then Secretary of State for Social Services) was careful to insist that allowing health authorities to raise charitable funds:

‘no more undermines the principle of a NHS free at the point of use than does [the acceptance of] free gifts.... If a small local hospital is threatened with closure because resources are needed to finance the commissioning of a modern new hospital.... Is it unreasonable that the health authority could indicate that, if voluntary funds were forthcoming to meet the whole or part of the cost of keeping that small hospital open, it would be happy to make an arrangement to do just that?’¹⁷⁴.

Other Conservative MPs argued that allowing health authorities to raise money locally would ‘stimulate community involvement and interest in the health service’. Jenkin had previously spoken of the possibility of transferring hospitals to voluntary organisations at ‘peppercorn rents’¹⁷⁵. Similar suggestions were made in debates during the 1980s, with Rhodes Boyson memorably arguing that denationalising hospitals and transferring

174 H. C. Deb., v. 976, c. 662, 19/12/79.

175 H. C. Deb., v. 970, c. 1798, 18/7/79.

them to the control of community-based organisations would allow them to raise 'vast amounts of money'¹⁷⁶. Interestingly, Jenkin at one point referred to the NHS as a series of local services, responsive to local needs and with a strong involvement from the local community¹⁷⁷. Such localism is in one sense a strength, though from another point of view a key issue is how to make it responsive to local needs without compromising the NHS's goals of providing an equitable service. In a wider context the Conservative governments also encouraged health authorities to engage in income generation activities, pursuing commercial opportunities to sell services, exploit the assets of hospitals or open up hospitals to retailers¹⁷⁸. Though not examined here, such entrepreneurial activities arguably contributed to geographical differentiation in funding within the NHS.

The recent growth and current scale of charitable funds have been examined in a series of publications¹⁷⁹ and most recently in annual contributions to *Charity Trends*¹⁸⁰. The total income of NHS charitable funds rose from £57 million in 1982-3 to £315 million in 1998-9. The value of assets held by NHS charitable funds grew from £247 million in 1982-3 to £1.7 billion in 1997-8. This reflects a combination of increased fundraising

176 H. C. Deb., v. 125, c. 872, 18/01/88.

177 Speech to National Association of Health Authorities, 27/06/80, quoted in R. Klein, 'Health policy 1979-83: the retreat from ideology?', in P. Jackson (ed.), *Implementing government policy initiatives: the Thatcher administration, 1979-83* (London, 1985), p. 196; N. Deakin, *The politics of welfare* (London, 1987), p. 98.

178 C. Davies, 'Things to come: the NHS in the next decade', *Sociology of Health and Illness* (1987), 9, 302-17.

179 L. Fitzherbert, *Charity and the national health* (London, 1989); M. Lattimer and K. Holly, *Charity and NHS reform* (London, 1992); M. Lattimer, *The gift of health* (London, 1996).

180 K. Holly, 'NHS Charitable Trusts', in C. Pharaoh and M. Smerdon, *Dimensions of the voluntary sector*, 1998 edition (West Malling, 1999), pp. 129-143.

activity and a boom in the value of stocks, shares and property. In real terms this represents roughly a threefold increase in charitable income and assets: income in 1982-3 would equate to £117 million at 1998 prices; and the asset base of NHS charitable funds in 1982-3 was worth £529 million at 1998 prices. NHS charitable funds in 1998 equated to approximately 1% of the revenue budget of the NHS Hospital and Community Health Services (HCHS). This represents an increase from the early 1980s, when the figure for trust fund income was 0.7% of the HCHS budget. This reflects the relatively generous treatment given to the NHS so that, although in real terms charitable income has trebled, when expressed as a proportion of NHS expenditure its value has risen by about 50%.

These figures conceal major variations between individual trusts and, therefore, between places. For the 1998-9 financial year, 57 trusts or Special Trustees had income from charitable sources in excess of £1 million and the total for these organisations was £220 million or nearly 75% of NHS charitable income in England. Some familiar institutions led the way. Five institutions (four of them in London) had a total income of £95 million from charitable sources: Guy's Hospital (£32 million), Great Ormond Street Hospital (£23 million), St Bartholomew's and the London Hospital (£15 million), the Christie Hospital, Manchester (£15 million) and the Royal Marsden (£10 million). The remaining hospital charitable trusts with income over £1 million were almost invariably associated with teaching or specialist institutions, or large urban general hospitals in major cities, with the occasional exception such as the West Midlands Ambulance Trust. This pattern clearly reflects the ability of such high profile, glamorous institutions to capture the public imagination. In contrast there were 133 NHS Trusts with a charitable income of under £100,000, and the great majority of these were providing community health, mental health or ambulance services.

An alternative way of looking at these figures is to compare them with the revenue budgets of their 'parent' NHS Trusts. For three institutions – Christie Hospital (21%), Great Ormond Street Hospital (11%) and Guy's Hospital (10%) – charitable income equated to over 10% of their total income. For a further 24 NHS Trusts, charitable income was equivalent to over 2% of total income. Expressed in this way the figures give rather more prominence to smaller institutions, for whom relatively small amounts of charitable income are larger in proportion to total budgets. But whether expressed in absolute terms or in comparison to total income, most of the benefits of charity are confined to a relatively small number among the 500 or so NHS Trusts in existence in 1998-9.

This impression is reinforced if we consider the scale of the asset base held by individual trusts. As noted previously, the teaching hospitals were permitted to retain control of their endowments after 1948, through the Special Trustees of the hospitals. These Trustees control substantial assets. As of 1998, assets valued at £575 million were controlled by the Special Trustees of: St Thomas's Hospital (£256 million), St Bartholomew's Hospital (£114 million), Guy's Hospital (£111 million) and Great Ormond Street Hospital (£92 million); all are located in London¹⁸¹. The Special Trustees of hospitals in London held assets valued at a combined total value of £860 million in 1997-8 and, as an indication of growth in these funds, a previous estimate for 1996-7 was £639 million¹⁸².

For those concerned about precisely how and where the boundary should be drawn between public and private finance, a key issue is whether or not charitable income is being used to

181 The source for these figures is the Charities Aid Foundation's online publication, *Dimensions 2000 online*, available at www.cafonline.org.

182 K. Holly, *NHS charitable trusts* (1997).

replace public funds or whether such sources complement what the state provides. The legal position is essentially that statutory authorities should not employ charitable funds for purposes which would otherwise be met out of rates, taxes or other public funds¹⁸³. But this definition, which has generally meant that funds have been applied to projects in the areas of patient and staff welfare, medical research, and preventive health programmes (especially those involving innovation), now seems out of line with trends in the use of charitable funds. In particular what was formerly the 'use of funds to purchase exceptional and experimental machinery has developed into routine buying of standard equipment', such as scanners. Similarly, major appeals have been launched not just to buy novel pieces of equipment but also to finance the reconstruction of buildings¹⁸⁴. There have also been occasional cases in which health authorities have launched appeals the purpose of which was to provide funds to supplement what they can deliver using Exchequer resources¹⁸⁵.

Data on expenditure of NHS charitable funds are broken down into five categories: patients' welfare and amenities; staff welfare and amenities; research; contributions to the NHS; and a 'miscellaneous' category. Expenditure in these five categories totalled £211 million in 1998-9, of which £101 million was categorised as 'contributions to the NHS'. In the case of 20 NHS Trusts the sums expended in this category equated to over 1% of the budget. These substantial sums will probably include large items of capital expenditure but their size has led some authors to suspect that charitable funds are being used to support the revenue budget of the NHS. Holly states that, when queried about what is covered by expenditure under this head-

183 R. Meakin, *Charity in the NHS: policy and practice* (Bristol, 1998).

184 Williams, *op. cit.*, p. 102.

185 Source for this is occasional reports in the *Health Service Journal*.

ing, the Department of Health ‘responded with a vague reference to “general running costs”¹⁸⁶. If Holly is correct in her inference that charity is supplementing revenue budgets, then access to charitable funds could play a crucial role in easing financial pressure on health authorities and trusts. A further relevant point is that while charities may fund capital equipment, the associated running costs must be found from within existing revenue budgets. These additional demands are a general weakness of charitable fundraising. It has been suggested that they are also a weakness of the New Opportunities Fund, which is providing new or replacement equipment for cancer treatment, but is not making any contribution to running costs¹⁸⁷.

The contemporary impact of charity is a highly uneven one. The resources generated in this way, and the charitable asset base, remain heavily skewed towards high-profile institutions with a preponderance in central London. Referring back to our sample data on the endowments of pre-NHS institutions, not much has changed here in 50 years to alter the basic contours of this pattern. It may be that those Trusts best placed to raise funds privately are continuing to expand charitable fundraising to supplement NHS resources.

Continuing the theme, developed previously, of the increasingly entrepreneurial character of health policy, it is notable that some NHS hospitals generate substantial sums from treating private patients as well as from charitable sources. Thus, in 1997-8, there were seven NHS Trusts where income from private patients exceeded 10% of their ‘core’ income from NHS services, and a further 16 in which this proportion exceeded 5%. The NHS institutions with the most private income included most of the major teaching hospitals in London (Guy’s

186 K. Holly, (1997), p. 100.

187 N. Burnet, R. Benson, M. Williams and J. Peacock, ‘Improving cancer outcomes through radiotherapy’, *BMJ* (2000), 320, 198-99.

and St Thomas' being a significant exception). Non-statutory sources of income are clearly of great significance to such institutions and data indicate steady growth over the 1990s in both charitable and private patient income.

This raises a quite different scenario. It may be the case that certain of the most prominent hospitals in the UK will develop a much more diversified funding mix, drawing on commercial and charitable resources as well as receiving the bulk of their income from public funds. However, this would impart a rather different dynamic to the process of health service development, in which access to health care depended to a growing degree on locally available resources. This would have profound consequences for equity.

4.3 Capital appeals

There have been several measures which take the role of charity much further than that of straightforward fundraising for the purposes of augmenting the ability of a hospital to promote patient welfare or research, the traditional preserves of charitable fundraising within the NHS. These involve the raising and application of charitable funds for major capital projects. According to Lattimer some £170 million was raised through charitable appeals for prominent central London hospitals in the 1980s¹⁸⁸.

The best known of these was the national fundraising campaign, the 'Wishing Well' appeal, for the redevelopment of the Great Ormond Street Children's Hospital. The appeal was deemed necessary because of the limited capital funds available: the Department of Health refused to fund the entire cost of rebuilding, stating instead that it would add another £30 million to funds raised by the appeal. To put this in context, at the time

188 M. Lattimer, *The gift of health* (London, 1996).

the NHS's capital development programme was worth around £1 billion per annum. It was suspected that the Great Ormond Street redevelopment was a useful demonstration of what charitable effort might achieve if given free rein. The appeal's title carried certain semantic overtones: the idea that the hospital's financial difficulties (the cost of redevelopment) could have been 'wished away' might have had certain attractions but was plainly wishful thinking. Clearly not all hospitals could be 'wished well' in this way.

In narrowly financial terms the appeal was a success, but it was criticised on various grounds. One concern was that it might have been more rational to redevelop the hospital on a redundant hospital site on the outskirts of London, close to the M25 motorway, which would have made the institution substantially more accessible to patients and visitors from the North and Midlands. As a national centre of excellence, funded by taxpayers from all regions, there was an obvious equity argument here, and the proceeds from selling the existing Great Ormond Street Hospital and its site in central London would have easily covered the costs of such a relocation. One commentator suggested that this option was rejected because of the preferences of hospital consultants for a location close to their private consulting rooms in Harley Street, demonstrating how (just as in pre-NHS days) the influence of consultants could shape access to care¹⁸⁹.

More generally, while the appeal was undoubtedly successful, it implicitly pitted hospitals in different areas in competition with Great Ormond Street for appeal funds. Examples of this were reported from Manchester, where fundraisers for Great Ormond Street confronted people attempting to raise money for their 'own' local children's hospital; and from Liverpool, where nurses allegedly clashed with supermarket managers who

189 I. Williams, *The alms trade*, p. 104.

had staged ‘Wishing Well’ collections¹⁹⁰. Commentators questioned the inequities that would result from reliance on charity, observing that ‘worth and need cannot be measured by glamour, but they are’¹⁹¹. Most other hospitals lacked the ‘famous friends’ who had backed the Great Ormond Street appeal.

Great Ormond Street Hospital was not, of course, the only institution to benefit from charitable appeals of this kind. Nor was it the first to use charitable funds to leverage additional resources from government. According to Lattimer many of the big London hospitals had done so during the 1980s and 1990s. He instances St Bartholomew’s Hospital, where £18 million in government support supplemented £30 million in charitable donations; and Guy’s Hospital, where £100 million had been committed by government to add to £40 million from charitable sources¹⁹². It was also suggested that some of the resources available to the Special Trustees were put to use in resisting hospital rationalisation in London¹⁹³, while Lattimer suggests that the political contacts made through fundraising gave certain hospitals considerable influence¹⁹⁴. What is undeniable is that the very success of charitable appeals in London placed obstacles in the way of planned rationalisation of the capital’s acute hospital services.

The Tomlinson Report of 1992 illustrates this issue very well. This report sought to rectify the imbalance in London between the pattern of hospital services and the distribution of the population. It was a reaction to the difficulties caused by indiscriminate rationalisation arising from the NHS reforms. Tomlinson made recommendations which directly threatened

190 I. Williams, *The alms trade*, p. 104.

191 B. Levin, *The Times*, 13/01/89, quoted in Williams, p. 105.

192 M. Lattimer, *The gift of health*, p. 45.

193 K. Holly, *op. cit.*

194 M. Lattimer, *The gift of health*, p. 125.

the future of several hospitals which had raised substantial charitable resources. Tomlinson noted that several hospitals had incurred heavy expenditure, and the role of charity in that process was recognised, but Tomlinson argued that 'such sunk costs, however recently incurred, are small compared to the revenue costs of the NHS; they should not dictate strategic development in London'¹⁹⁵.

The issues can be illustrated with reference to Guy's Hospital. With substantial support from Sir Philip Harris (of the carpet company, Harris Queensway), Guy's had, by the early 1990s, received guarantees from charities which meant that some £44 million of the projected £140 million cost of redeveloping the hospital would be met by charities. However, the Tomlinson Report recommended that most clinical services would relocate from Guy's to St. Thomas' Hospital. The reaction by several charities was either to withhold donations previously agreed, or to demand repayment¹⁹⁶. The final decision on Guy's involved the preservation of most of Phase III of the Guy's redevelopment, in which charity had played a key role. Other London hospitals, such as the Royal Marsden and the National Hospital for Neurology and Neurosurgery, were reprieved on similar terms.

In another case, a health authority in Manchester, concerned at the potential loss of an £800,000 charitable grant, began building a new unit for treatment of cystic fibrosis, notwithstanding the fact that agreement had not been reached between all the health authorities concerned over the disposition of all related services. Though conflicts between the relevant health authorities were ultimately resolved, this case (as with Guy's)

195 Sir B. Tomlinson, *Report of the inquiry into London's health service, medical education and research* (London, 1992), p. 30.

196 O. Dyer, 'Charities demand money back in Guy's changeover', *British Medical Journal* (1994), 308, 935.

indicates the potential for decisions to be influenced by considerations of the availability of charitable funds¹⁹⁷. The London cases illustrate the difficulties of planning a hospital system in which the availability of charitable funds varies so substantially and gives the beneficiaries of charity considerable autonomy. There is a long history of attempts to resolve these difficulties¹⁹⁸.

Finally, as an indication of the continued salience of this issue, we note the recent announcement of a fundraising campaign to construct an entirely new children's hospital in Cardiff. This is said to be the first attempt since 1948 at such a project¹⁹⁹. It raises the issue of precisely where the boundary between public and private responsibility is to be drawn. Going back to the 1950s, a key argument used to discourage health authorities from engaging in such appeals was that decisions on the allocation of scarce capital could in effect be pre-empted. If appeals failed to reach their targets, it was suggested, there would be pressure on the state to step in and close any funding gaps. In addition to the potential funding gap, there are worries that this proposal is being put forward in isolation from other decisions as to the strategic development of hospital services in the Cardiff area.

It is very clear, then, that the scale of resources from non-statutory sources available to certain hospitals gives them con-

197 A. Webb and S. Hanley, 'The conflict in transferring a cystic fibrosis specialist service between two hospitals in Manchester', *BMJ* (1997), 315, 1009-11.

198 G. Rivett, *The development of the London hospital system, 1823-1982* (London, 1986), 161-7, 205-25; M. Powell 'A century of hospital planning in London: from the House of Lords inquiry to the Tomlinson report', *London Journal* (1996), 21, 164-80.

199 T. Shifrin, 'Bevan can wait', *Health Service Journal*, 25/05/2000, pp. 14-15.

siderable scope in terms of financing capital development. But this does not necessarily mean that such development takes place in locations or hospitals which most need it, nor in a manner consistent with the NHS's strategic priorities. Substantial charitable resources can, in principle, reduce an NHS Trust's requirement to obtain capital either from the public sector directly or via the Private Finance Initiative, and thus can place certain Trusts at an advantage in terms of pursuing aspirations for capital development²⁰⁰.

4.4 Transferring NHS facilities to charitable trusts

Ownership by charitable trusts features strongly in the proposals of associationalists and pro-voluntarists. What lessons can be learnt from the evidence of the transfer to charitable trusts of a (relatively small) number of hospitals?

Again, a well-known example is connected with the Great Ormond Street Children's Hospital. The country branch of the hospital, at Tadworth Court in Surrey, re-opened under the 'Tadworth Court Trust', raising funds partly through the Department of Health, partly through contracts for treatment of NHS patients, and partly through charitable donations and fundraising. Although the existing workforce were to be retained at the hospital, the Tadworth Court Trust refused to recognise NHS trade unions, and initially stated that the wages it could pay would depend on the funds available to it. George Gardiner, MP for Reigate, hailed this 'new and positive' approach, but newspaper editorials pointed out that most hospitals in difficulties lacked Tadworth Court's political clout²⁰¹.

200 Anonymous referee's comments.

201 *The Guardian* 15/03/83, 22/03/83.

Around the same time as the Tadworth Court development, at least one health authority (the then South East Thames Regional Health Authority) actively investigated the possibility of returning some hospitals to community ownership as charitable trusts. One of the district health authorities in the South East Thames region seriously investigated this but the project never came to fruition (not so much because of funding difficulties but rather because of uncertainties about the future pattern of hospital services in the district).

Most famously, perhaps, there was also the attempt to take St Bartholomew's Hospital in the City of London out of the NHS as a charitable trust. Responding to the threat of closure arising from the Tomlinson report, the proposal was developed by leading surgeons working at St Bartholomew's, and representatives of the City of London Corporation and major financial institutions. The intention was to maintain St Bartholomew's through a combination of private patient income, corporate donation, charitable fundraising and NHS contracts²⁰². However, the hospital was subsequently retained as part of a larger NHS Trust with the Royal London Hospital following a London-wide review instigated by the new Labour government after the 1997 election.

Not all hospitals have the high profile of St Bartholomew's and so it is not known with certainty just how many such proposals there have been, nor how many transfers have taken place. Some, such as Tadworth Court, received national publicity, but no central records have been kept. This section of the paper is therefore based on data collected less systematically from sources such as the Health Service Journal and from bodies such as the Community Hospitals Association.

202 A. Gilligan, 'City rides to the rescue of Bart's', *Sunday Telegraph*, 22/04/96.

The Community Hospitals Association directory identifies seven hospitals which have transferred out of the NHS into the ownership of independent trusts. These are small 'cottage hospitals' located in: Brackley (Northamptonshire), Holbeach (Lincolnshire), Hoylake and Tarporley (Cheshire), Odiham (Hampshire), Rye (East Sussex) and Tetbury (Gloucestershire). This small number prohibits easy generalisation but it is notable that all are in relatively prosperous small towns. It is also known that campaigns to retain hospitals as charitable trusts have in recent years been launched in Suffolk, Hampshire and Oxfordshire²⁰³. Some of these, such as the on-going campaign to retain the Lord Mayor Treloar Hospital (Alton, Hampshire), seek to draw on quite traditional sources of charitable effort involving royal or aristocratic patronage and elite philanthropy. The pattern of these developments is not surprising. In order to switch to community ownership and control, it is reasonable to surmise that a hospital would require additional sources of revenue. If relying to a greater extent on volunteer labour, national surveys on volunteering indicate a bias towards higher levels of such activity among middle-class, middle-aged individuals. One might therefore anticipate that such partnerships, or transfers of ownership, would be found in the more prosperous localities.

There are of course exceptions. The Mildmay Hospital, in London, closed by the NHS, reopened specialising in the care of people with AIDS. It receives funding from a range of statutory and charitable sources, and has substantial support from volunteers. Other examples, which do not involve a change of ownership but which have involved diversification of institutional funding bases, are to be found in the growing community hospitals movement. A number of such initiatives are

203 *Health Service Journal*, various dates.

described, often eulogistically, by Emrys-Roberts²⁰⁴. The issue raised by these developments is a more wide-ranging one relating to the role of small hospitals in a hospital system showing tendencies to ever-increasing spatial concentration. Such facilities can undoubtedly play a valuable role but should their provision depend, at least in part, on charity, with its large element of chance?

There are of course advantages to such localism, which are emphasised every time proposals for centralisation or hospital closure are brought forward. In particular, the status of hospitals as genuinely public institutions, owned by and open to all members of a community, has attractions for those who are concerned at the remoteness and impersonality of large general hospitals. On the other hand, communities are likely to experience challenges in raising the funds to keep such hospitals in existence. Such initiatives might therefore be of value in encouraging participation in, and voluntary support for, health care but we should be wary of assuming that they can be generalised throughout the country.

4.5 Summary

It is helpful to begin by reviewing the arguments in favour of voluntarism outlined in Chapter 2. These relate to its flexibility and responsiveness to need, its capacity to foster diversity in provision as part of a pluralistic welfare state, and its ability to motivate citizen commitment and participation, thereby fostering a more democratic society. Implicit in these arguments are critiques of an impersonal, centralised and bureaucratic welfare

204 M. Emrys-Roberts, *The cottage hospitals 1859-1990: arrival, survival and revival* (Motcombe, 1991); see also J. Higgins, *The future of small hospitals in Britain* (Southampton, 1993); H. Tucker and N. Bosanquet, *Community hospitals in the 1990s: a case study* (Chichester, 1991).

state, though there are of course elements of caricature in some of them. To what extent does the contemporary evidence bear out these contentions?

Firstly, the evidence on the distribution of charitable resources suggests that current developments are reinforcing disparities between places, and between sectors of the NHS. This indicates responsiveness to local prosperity and to the financial appeal of institutions, rather than to social need. Insofar as one can generalise about the distribution of the small numbers of institutions transferred to charitable ownership, the same is true of that dimension of voluntary effort. Hence the result appears likely to be wide variations in the availability of charitable resources. Although we might welcome this as evidence of greater localism and community involvement, and as an indication of a welfare system moving in a more pluralist direction, we would also have to acknowledge the associated inequalities in the availability of resources.

We would also have to acknowledge two further problems: an apparent mis-match (both sectorally and spatially) between the distribution of funds and the pattern of need for health care; and the way in which the distribution of charitable funds complicates the process of planning NHS services. On the former point, a key issue is that charitable funds are not targetted on the NHS's priority areas. This point is made very well in a recent analysis of philanthropic spending on health care in London, which shows an overwhelming bias towards medical research funded by the Special Trustees of the London teaching hospitals²⁰⁵. Conversely, primary care and community health services receive very limited funds from such sources. The same

205 C. Pharaoh and I. Mcroft, 'Philanthropic funds in London's health', reported in R. Dobson, 'NHS still rattling tins for funds', *BMJ* (2000), 321, 982. This is based on a report carried out by the Charities Aid Foundation and commissioned by the King's Fund and the Guy's and St Thomas' Charitable Trust. It is due to be published early in 2001.

point could also be made using our data on the funds available to NHS Trusts.

On the latter point – the planning of NHS provision – we have given examples of cases in which the availability of charitable funds, or the wishes of donors, are at odds with NHS policies. More generally, when one recalls that charitable appeals are often predicated on attachments to a particular hospital, there is an implicit tendency for charitable fundraising to ‘freeze’ the distribution of resources. Tackling this would, however, require legislative changes permitting much greater flexibility in the use of charitable funds.

The final argument made by advocates of voluntarism relates to its promotion of participation, as opposed to the passivity they claim is engendered by the welfare state. It is clear that voluntary fundraising engages substantial numbers of people, as does voluntary work in hospitals. It is rather less clear that this promotes community control over NHS facilities, since fundraising is usually for a specific purpose and is carried out by a body which is formally separate from the NHS Trust on which funds are to be expended. Regardless of the amount of charitable effort by a community on the part of their local hospital, the citizens of that community have no formal rights of membership of the hospital’s board of directors. The condemnation of hospital closure decisions by those who have raised considerable sums of money is a familiar scenario. Without a further reorganisation of NHS governance structures, this situation will not change. In fact the Labour government’s ‘NHS Plan’ for England appears to limit community participation still further, by proposing the abolition of Community Health Councils²⁰⁶. Like its Conservative predecessor, this implies that the government wishes to encourage active citizenship, but very much on terms dictated by the state.

206 Department of Health, *The NHS plan. A plan for investment. A plan for reform*, Cm 4818-1 (London, 2000).

Box 4.1 **Charitable funding of the NHS today**

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- The contemporary impact of charity remains highly uneven.
- Charitable income and the charitable asset base remain heavily skewed towards high profile institutions, many of them in London.
- The pattern is similar to that before the creation of the NHS.
- Charitable funding for capital expenditure is used to leverage additional government financial support.
- A small number of ex-NHS ‘cottage hospitals’ in prosperous small towns have been transferred to the ownership of charitable trusts.

5 CONCLUDING COMMENTS

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‘Charity always does too much or too little; it lavishes its bounty in one place and leaves people to starve in another’ (John Stuart Mill)²⁰⁷

In this paper we have reviewed various arguments for and against a revived voluntarism in the NHS. In order to interrogate their strengths and weaknesses we have presented both historical and contemporary evidence. The parallels between the past and present are not exact but are nevertheless illuminating. Evidence from both periods illustrates that John Stuart Mill’s words remain highly pertinent. Of course, the very clear and considerable spatial inequalities of the inter-war years will not return as long as the NHS remains funded through taxation, and only the most committed pro-voluntarists and privatisers would call for a denationalisation of hospital provision. It might therefore be suggested that charitable contributions ought to be welcomed insofar as the state’s resources are inevitably limited.

However the analysis of historical sources presented here serves as a reminder of why reliance on voluntary effort to support hospitals was rejected. Our analysis offers significant new insights because of our ability to produce data for consistent sets of hospitals and (in the case of financial statistics) at constant prices. We emphasised equity, financial stability, planning and accountability as four central criteria. For all of these many of the problems of the pre-NHS era have reappeared as charitable activity around health care has revived. There are significant variations between regions in terms of access to charitable income and these are even more pronounced between individual hospitals. Charitable income is also unstable, varying from year to year, and may have unpredictable revenue consequences.

207 Quoted in T. Lloyd, *The charity business* (London, 1993), p. 178.

There are also issues of planning. Large charitable donations may become an obstacle to the rational reconfiguration of services, as has been evident in some prominent disputes. It could also be argued that by tying large charitable appeals to the reconstruction of particular hospitals, such as Great Ormond Street, opportunities have been missed to consider potential relocations of facilities. Furthermore, charitable fundraising may become an end in itself, distracting from the wider purposes of running health care services²⁰⁸. Finally, there are important questions of accountability: can the wishes of donors take precedence over those of health authority members? Can decisions taken by the special trustees of hospital endowments pre-empt or run counter to other decisions in the NHS?

Our discussion has emphasised core themes of uneven development, equity and planning. Looking to the future a further twist to this tale can be given if one considers emerging patterns of uneven development in the UK. Despite the good overall performance of the economy in recent years, regional disparities have remained substantial, despite official questioning of the scale of the gap between places. The South and South East of England, especially the Outer London area and the favoured corridor along the M4 motorway, are plainly booming in economic terms²⁰⁹. Future developments in the location of economic activity – such as the government's preference for clusters

208 It may also have hidden costs: the kind of energetic pursuits beloved of contemporary fundraisers may rebound on health care providers in the form of attendances at casualty departments. For example, an audit of charitable parachute jumps in Scotland found that every pound raised for charity cost the NHS £13.75 in return! See C. Lee, P. Williams and W. Hadden, 'Parachuting for charity: is it worth the money? A 5-year audit of parachute injuries in Tayside and the cost to the NHS', *Injury* (1999), 30(4), 283-7.

209 J. F. Mohan, *A united kingdom? Economic, social and political geographies* (London, 1999).

of high-technology industry²¹⁰ – will further exacerbate tendencies towards concentration of wealth. Even if the ‘dot.com’ revolution has lost some momentum, there is no doubt that many individuals have made substantial fortunes and the same is true of the financial services sector. Such wealthy individuals may well wish to memorialise themselves with large capital donations but given the distribution of places in which these people might be found – the Home Counties, the high-technology corridor west of London, or ‘Silicon Fen’ around Cambridge – such largesse would widen gaps in the availability of funds. We would expect to see differential growth between regions in access to charitable resources. Arguments that charity and the NHS have always been intertwined do not answer the potential threat to equity posed by these developments. Studies of the pattern of mortality decline show that the areas best placed to benefit will be the healthiest parts of the country. The mortality experience of the North and West of Britain has consistently lagged behind that of South East England²¹¹ but the former locations have much less access to charitable funds than the latter. Such funds are generally tied to specific buildings in specific locations, and their distribution therefore bears little relation to the pattern of need for health care.

We pose three key questions in conclusion. The first concerns relationships within the voluntary sector. There are justifiable concerns that appeals for health-care-related charities will swamp charitable appeals for other causes. This may not be apparent from overall trends in charitable income at a time of steady economic growth, but it may become an issue in a harsh-

210 Department of Trade and Industry, *Our competitive future* (London, 1998).

211 D. Dorling, G. Davey-Smith, D. Gordon, M. Shaw, *The widening gap* (Bristol, 1999).

er economic climate. Clearly the market muscle of the NHS, in terms of the resources it can apply to fundraising and the emotive appeal of health care, can outweigh that of other causes which are less well resourced and less prominent.

Secondly, charity is inherently uneven in its benefits. Charitable funds are usually tied to a specific hospital or piece of equipment in a particular location. The wishes of donors must be observed and therefore steering charitable funds towards less glamorous locations and purposes (e.g. away from acute hospitals and towards community care) is almost impossible. What might be done to target charitable resources more effectively? There have been attempts to establish suitable mechanisms in the past. The original goal of the King's Fund was to act as a redistributive clearing house for London charity, though this goal was only partially fulfilled. The Sankey Report of 1937 recommended the 'creation of a regional fund for the benefit of all hospitals'²¹². Drawing on these precedents, Lattimer suggests that charitable funds might be merged into a large independent foundation, which could pump-prime development of much-needed primary and community care services (he was referring to London but his proposal would be equally applicable elsewhere)²¹³. There have been suggestions that legislative changes relating to the regulation of charitable trusts will permit greater flexibility in the use of funds²¹⁴ but it remains to be seen just how much flexibility there will be, or how much redistribution might be possible. It seems likely that those areas of health care that have always lagged behind in attracting charitable funds will continue to do so, although it is true that the

212 British Hospitals Association, *Report of the Voluntary Hospitals Commission* (London, 1937), recommendation 8, p. 63.

213 M. Lattimer, *The gift of health*.

214 National Audit Office, *Charitable funds associated with NHS bodies* (London, 2000), HC-516.

118 New Opportunities Fund, drawing on the National Lottery, is making money available for less glamorous causes.

The third and crucial point raised by both historical and contemporary research concerns precisely where the boundary between public and private provision ought to be drawn. As Julian Wolpert points out, we cannot be agnostic about this; we need to decide what charity can and cannot do²¹⁵. A central issue here is whether, and to what extent, greater inequality will be the inevitable corollary of greater localism and partnership in service delivery. The recent concordat between the NHS and the private and voluntary sectors²¹⁶ implicitly acknowledges that NHS patients in areas with substantial private or voluntary resources will benefit from access to such facilities. The agnosticism implicit in this concordat belies these tendencies to inequality. Perhaps in this sense we will see the NHS revert to being a collection of local services. As with so many debates on the British system, ultimately the issue is what we mean by a national health service, if indeed we ever had one.

215 J. Wolpert, *What charity can and cannot do* (New York, 1996), available online at <http://epn.org/tcf/tccd.htm>.

216 Department of Health, *For the benefit of patients* (London, 2000).

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