Nonprofit and Voluntary Sector Quarterly
http://nvs.sagepub.com

London's Voluntary Hospitals in the Interwar Period: Growth, Transformation, or Crisis?

Martin Gorsky and John Mohan

Nonprofit and Voluntary Sector Quarterly 2001; 30; 247
DOI: 10.1177/0899764001302005

The online version of this article can be found at:
http://nvs.sagepub.com/cgi/content/abstract/30/2/247

Published by:

http://www.sagepublications.com

On behalf of:

Association for Research on Nonprofit Organizations and Voluntary Action

Additional services and information for *Nonprofit and Voluntary Sector Quarterly* can be found at:

Email Alerts: http://nvs.sagepub.com/cgi/alerts

Subscriptions: http://nvs.sagepub.com/subscriptions

Reprints: http://www.sagepub.com/journalsReprints.nav

Permissions: http://www.sagepub.com/journalsPermissions.nav

Citations http://nvs.sagepub.com/cgi/content/refs/30/2/247

Downloaded from http://nvs.sagepub.com by on February 9, 2010

London's Voluntary Hospitals in the Interwar Period: Growth, Transformation, or Crisis?

Martin Gorsky
University of Wolverhampton

John Mohan
University of Portsmouth

The establishment of the British National Health Service in 1948 was a watershed for the nonprofit sector, as the voluntary hospitals were taken into public ownership. This article surveys the voluntary hospitals of London in the last two peacetime decades of their existence. Although this was a period of significant expansion for the hospitals, there were also difficulties looming. City-wide data and records of individual institutions are used to explore the risk of deficit, the hospitals' asset base, the demand for expenditure, and the changing basis of income. The analysis confirms and augments earlier discussion of gathering financial hardship. Finally, the growth of the municipal hospital service is detailed. The London County Council's enthusiastic development of publicly funded institutions added to the problems of the voluntary sector. Public/nonprofit partnership remained underdeveloped, voluntary fundraising was undermined, and principled opposition was articulated by council members.

Although the history of nonprofits in the 20th-century United States is characterized by growth and expansion, the British experience was rather different. Here, the advance of state agency dramatically curbed the activities of a voluntary sector that had flourished during the Victorian period. After the Education Act of 1870, publicly funded schooling began to supersede the voluntary elementary schools. The Liberal welfare reforms of 1906-1911 saw the state enter the field of old-age pensions and sickness insurance for the

Note: We wish to thank David R. Green, David Hammack, Elsbeth Heaman, Beatrix Hoffman, Rodney Lowe, Martin Powell, John Stewart, and Keir Waddington for their helpful criticism of the first draft of this article. Earlier versions were presented at the European Social Science History Conference, Amsterdam, the Netherlands, April 2000 and at the History of Medicine Seminar, University of Birmingham; we are grateful to participants for their comments. Research for this article was funded by a grant from the Leverhulme Trust, whose support we gratefully acknowledge.

Nonprofit and Voluntary Sector Quarterly, vol. 30, no. 2, June 2001 247-275
© 2001 Sage Publications

Downloaded from http://nvs.sagepub.com by on February 9, 2010

working class, hitherto the province of the friendly societies. For the voluntary hospitals the watershed was the establishment of the welfare state by the post-war Labour government, when, with the founding of the National Health Service (NHS) in 1948, they were taken into state ownership after 200 years of independent existence. By the latter part of the 20th century, the state had emerged as the principal provider of education, social security, and health care, and the British voluntary sector had become, in David Owen's memorable phrase, "junior partner in the welfare firm" (Owen, 1964, p. xix).

The subject of this article is the voluntary hospital in the last two peacetime decades before nationalization. Here the term *voluntary hospital* is used as it was understood by contemporaries: to denote a self-governing institution funded principally by philanthropy and contributory schemes rather than by taxation or private payment and in which the consultants and management bodies were mostly honorary and unpaid (Braithwaite, 1938, pp. 2-3; Political and Economic Planning [PEP], 1937, pp. 16-17, 230-240; Sankey Commission, 1937, pp. 7-8; Stone, 1927, p. 12). In the 1930s, they provided about one in three of the nation's hospital beds, the remainder being located in the public sector (Pinker, 1966, p. 61). Indeed, the structure of institutional care broadly mirrored the American division between the charitable voluntary hospital dedicated to the cure of acute sickness, and the state-funded almshouse, "that residuary legatee of a city's misery" (Rosenberg, 1987, p. 23; Stevens, 1989, pp. 9-10, 27-29). The British voluntaries were also oriented principally to treatment of the short-stay patient suffering acute illness. They too were the centers of teaching and research, with eminent medical schools allied to large general hospitals such as St. Bartholomew's, St. Thomas's and Guy's (Rivett, 1986, pp. 51-61). And as in America, the public sector accommodated the sick poor, along with the aged, the "lunatic," and the destitute in Poor Law workhouses. By the early 20th century, some separate public infirmaries had emerged, but in general, they housed the elderly, chronic patient, their staff-patient ratios were inferior to the voluntaries, and the stigma of pauperism was slow to dissipate (Abel-Smith, 1964, pp. 83-100; Crowther, 1981, pp. 162-166, 182-190; Pinker, 1966, pp. 110-112). The third provider was the municipal or county council (fiscally and spatially distinct from the Poor Law administration), which had, since 1867, been empowered to build and maintain isolation hospitals for infectious diseases (Abel-Smith, pp. 119-132). Public hospital administration was later restructured when the Local Government Acts of 1929 terminated the Poor Law and brought its institutions under the control of the councils, which were also permitted to open municipal general hospitals to care for nonpauperized acute and maternity patients (Abel-Smith, pp. 368-383; Powell, 1997, pp. 334-357).

It may seem perverse in a journal whose theme is the expansion of the non-profit sector to direct attention toward institutions that stood on the threshold of extinction. And indeed, the first generation of welfare state historians assumed that the internal weaknesses of the interwar voluntary hospitals had hastened the onset of state intervention. These were the disparities in quality

Downloaded from http://nvs.sagepub.com by on February 9, 2010

of staffing and infrastructure; the uneven geographical distribution of beds to which the "caprice of charity" (United Kingdom, 1946, col. 46) gave rise; and above all, the growing financial crisis that confronted the hospitals in the 1930s (Abel-Smith, 1964, p. 404; Eckstein, 1964, pp. 72-75; Lowe, 1993, p. 169; Titmuss, 1950, pp. 66, 504, chap. v, part iii; Webster, 1988, pp. 3-4). In addition, some claim that a growing consensus was emerging at the same time amongst bureaucrats, policy makers, and medical professionals in favor of an integrated regional organization of the hospital system (Eckstein, 1964, pp. 101-132; Fox, 1986; Klein, 1989, pp. 2-7). The extension of state supervision in the wartime emergency of 1939 to 1945 and the subsequent election of a Labour government dedicated to socialized medicine clearly hastened the founding of the NHS. However, the context in which a state medical service could emerge was provided by this earlier enthusiasm for planning coupled with a growing awareness of the inherent limitations of nonprofit hospitals: a case of "voluntary failure," in Salamon's (1995, pp. 44-48) more recent terminology.

There are however some good reasons for subjecting this explanation to renewed scrutiny. Not the least is the fact that the period 1921 to 1938 was one of enormous expansion, when total voluntary bed numbers in England rose from approximately 56,000 to 87,000 (Pinker, 1966, p. 81). Recent work has laid new stress on the flexibility and creativity of voluntary fund-raising, illustrated by the rapid growth of mass contributory schemes (Cherry, 1992, 1996, 1997). Historians of voluntarism can justifiably point out that there was nothing new about funding shortfalls in the 1930s and that financial crisis had been confronted and overcome before (Prochaska, 1992; Waddington, 1996, pp. 181-202; Yeo, 1976). It was also the case that nonprofit bodies such as the King Edward's Hospital Fund for London (King's Fund) and the Nuffield Foundation brought a fresh vigor to fund-raising, advocacy, and the representation of the sector (Prochaska, 1992). New research has made it clear that far from building a consensus, the shift to planning unleashed intense ideological conflict between the proponents of socialized medicine and defenders of the voluntary principle (Prochaska, 1992, chap. 5; Stewart, 1999; Webster, 1990, pp. 115-151). More generally, historians of British social policy are anxious to shed the whiggish or collectivist assumptions held to have influenced earlier narratives of the coming of the welfare state and to recover the neglected role of the voluntary sector (Finlayson, 1994, pp. 2-6; Prochaska, 1988, pp. xiii-xv). Present concerns with the bureaucratic inflexibility and democratic deficit of today's NHS have aroused interest in the earlier capacity of nonprofit arrangements to engage citizens and respond to local needs (Ham, 1996, pp. 37-51; Hirst, 1994). Polemical commentators now remember the voluntary hospital as the historic achievement of British individualism, doomed not by its own weaknesses but by the heavy hand of socialist planners (Green, 1996, pp. 33-37; Willetts, 1996).

The aim of this article is therefore to reevaluate the state of the voluntary hospitals in the interwar years. Specifically, it examines changes to their sources of funding and to the statutory framework in which they operated.

Downloaded from http://nvs.sagepub.com by on February 9, 2010

The purpose is to show how these forces shaped the hospitals' experience and to assess their role in creating the situation in which a state health service could be contemplated. There are several novelties. We present detailed empirical findings on aggregate and individual hospital accounts, which are used to analyze the extent and nature of the funding crisis. Here, we seek to improve on earlier conclusions that were based not on a sustained analysis of hospital finances but on the assertions of parliamentary and independent commissions and on a short-term increase in annual deficits recorded between 1937 and 1939 (Onslow, 1925, pp. 11-15; Sankey Commission, 1937, p. 8; Titmuss, 1950, pp. 456-457). We also provide full details of the changing sources of income and components of expenditure of hospitals between 1901 and 1942; previous accounts have relied on only a small number of sample years (Pinker, 1966, pp. 142-158; Prochaska, 1992, pp. 101-104). Finally, we consider anew the short-lived attempt to establish a viable public/nonprofit partnership between the voluntary sector and the new municipal hospitals that were brought into being by the Local Government Act.

For a variety of reasons, the focus of the study is London. First, the capital contained, by 1938, 146 voluntary hospitals, accommodating more than 25% of the nation's beds (King's Edward's Hospital Fund for London, Statistical Summary [KFSS], 1939; Pinker, 1966, p. 57) These included the oldest teaching hospitals (by their own estimation of international repute), busy general hospitals serving populous suburbs, and a plethora of specialist institutions either catering to a particular affliction or class of patient (Guy's, 1932). Second, London's experience was central to policy making. Earlier historians have shown that the protestations of financial crisis by London's teaching hospitals in 1938 provoked the first serious discussions within the Ministry of Health of future state subventions for the voluntary system (Honigsbaum, 1989, pp. 16, 26-29; Rivett, 1986, pp. 221-225; Webster, 1988, p. 22). Third, because the London County Council (LCC) became the largest public hospital authority in the country (and probably the world) during the 1930s, the city offers a unique example of the impact of tax-based municipal health care on philanthropic and voluntary traditions (LCC, 1932, pp. 6-7). Finally, the efforts of a philanthropic corporation, the King's Fund, to standardize accounting practices in the capital have left a uniform body of collated statistics and a comprehensive collection of reports from individual hospitals.

The first section establishes the extent of financial crisis through an examination of annual surpluses and deficits. Here, we have relied on the annual *Statistical Summary* produced by the King's Fund and the national *Hospitals Yearbook*, two sources that record hospital income and expenditure. We also ask how secure was the asset base of a number of large hospitals using the balance sheet published in the annual reports that individual institutions issued to their subscribers. Section Two analyzes the trends in expenditure that underpinned the growing difficulties and the changing composition of income that was the response. In the final section, we address the theme of public/third-sector relations, asking whether local authority health policy

Downloaded from http://nvs.sagepub.com by on February 9, 2010

strengthened or undermined voluntary institutions. The perspective of the LCC is provided by the minutes of its health committee, and that of the voluntary sector by the records of the London Voluntary Hospitals Committee. We conclude by drawing out some implications of these changes for the future shape of the British health service.

THE EXTENT OF FINANCIAL CRISIS

The state of hospital finances may be viewed from the perspective of either the *maintenance* or the *capital* accounts. Maintenance accounts recorded the annual income raised and current yearly expenditure, whereas capital accounts showed the accumulated fixed and disposable assets of the hospital, along with any loans and overdrafts (Stone, 1927, pp. 558-559). Both must be considered, as even recurrent deficits on a hospital's maintenance account may not have been serious when set against assets accumulated over many years.

Table 1 presents the extent of deficits on the maintenance account in 72 London voluntary hospitals whose income and expenditure statistics were consistently reported.[2] The sequence begins in 1921, as this is the first year in which the King's Fund recorded income data, and is extended as far as 1942 to capture the impact of war on hospital accounts. Column A shows there was a persistent risk of income shortfall throughout the period, with at least half of all hospitals in deficit in 1921, 1930, 1938, and 1939. Column B compares the situation in London with a sample of large provincial hospitals, revealing that those in the capital were more likely to experience deficits than comparable institutions elsewhere. Columns C to G disaggregate hospitals by size and type. They reveal that the type of hospital most vulnerable to shortfall was that with a medical school attached. The proportions of general and special hospitals (maternity, women's, children's, eye, chest, ear, nose, throat, skin, etc.) in deficit were on average similar. With respect to size, it was the larger institutions that were most likely to experience deficiencies, and the smaller that more usually enjoyed a surplus, at least until 1939, when state payments under the wartime Emergency Medical Services (EMS) scheme favored the larger institutions (Titmuss, 1950). Columns I and J report the scale of deficit: The former summing deficits in all those hospitals experiencing a shortfall in a given year, and the latter showing this as a proportion of the total income of those hospitals.

Comparison of Columns A, I, and J reveals a broad correspondence between trends in the scale and incidence of deficit throughout the sequence. A serious crisis followed the 1914-1918 war, as the pressure of the influenza pandemic and rising prices coincided with falling receipts (Abel-Smith, 1964, pp. 307-309, 323-324; Cherry, 1997, p. 312; Order of St. John, 1923, pp. 100-101; Patterson & Pyle, 1991, pp. 4-21). Wartime rises in personal taxation and the imposition of death duty on inherited property were both detrimental to

Downloaded from http://nvs.sagepub.com by on February 9, 2010

Downloaded from http://nvs.sagepub.com by on February 9, 2010

Table 1. Annual Deficit on Maintenance Account in London and National Voluntary Hospitals, 1921-1942

	1. Percentage of Voluntary Hospitals With Annual Deficit								*2. In London Deficit Hospitals*	
			Type (London)			*Size (London)*				
Year	*A London*[a] *(%)*	*B Britain*[a] *(%)*	*C Teaching (%)*	*D General (%)*	*E Special (%)*	*F >200 Beds (%)*	*G 51-200 Beds (%)*	*H <51 Beds (%)*	*I Total Deficit (£)*	*J Deficit as % of Income*
1921	68	*n/k*	100	59	65	90	62	54	390,515	24
1922	24	*n/k*	25	21	26	20	18	46	55,194	10
1923	28	*n/k*	42	24	26	45	21	23	84,370	11
1924	47	*n/k*	67	48	39	55	51	23	83,663	6
1926	42	16	58	28	48	60	36	31	198,250	17
1927	47	15	50	48	52	40	54	38	89,849	8
1928	40	19	67	28	42	60	36	23	97,270	7
1929	46	14	50	55	35	55	49	23	80,178	6
1930	50	22	67	41	52	50	56	31	137,961	9
1931	42	20	42	34	48	35	46	38	97,388	8
1932	35	14	50	34	29	55	28	23	63,812	5
1933	25	16	17	34	19	30	21	31	24,172	4
1934	35	9	50	28	35	45	33	23	60,501	5
1935	47	13	67	38	48	55	49	31	97,042	5
1936	43	19	67	38	39	60	38	31	157,979	9
1937	43	19	67	59	19	65	41	15	158,299	8
1938	56	23	75	62	42	75	51	38	209,280	9
1939	54	17	25	59	61	35	64	54	173,451	15
1940	17	9	0	21	19	5	26	8	25,685	11
1941	18	7	8	21	19	10	18	31	6,902	2
1942	19	5	17	21	19	20	26	0	34,807	6
n	72	66	12	29	31	20	39	13		

Source: Hospitals Yearbook (*HYB*, 1927-1943), Kings Fund Statistical Summary (KFSS, 1922-1925).
a. 72 London hospitals and 66 from England, Wales, and Scotland, which consistently reported financial data to *Burdett's Hospitals and Charities* and its successor, the *HYB*. The London set includes the teaching hospitals and most of the large general and special hospitals. Smaller hospitals are underrepresented. Summary national data are unavailable 1921-1925; whereas for London, these are drawn from the KFSS.

philanthropy: "the subscriptions of the Old Rich, who had become the New Poor, tended to decrease very considerably" (Order of St. John, p. 101). The immediate crisis was rapidly overcome by a combination of government grants of £225,000, and charitable appeals: £413,214 from the King's Fund and £250,000 from the Joint War Committee of the Red Cross and Order of St. John (King Edward's Hospital Fund for London Annual Report [KFAR], 1922, p. 29, 1924, p. 6). Numbers in deficit remained high from the mid-1920s, with 1926 a year of notable shortfall as industrial disputes pushed up fuel prices (Guy's, 1927; Royal Northern Hospital, 1927; Westminster Hospital, 1927). More experienced difficulties during the slump, although again these proved to be short term (KFAR, 1931, pp. 15, 23, 25, 28). However from 1933, there was a marked rise in the extent and scale of deficit, which was only halted with the injection of state expenditure under the EMS.

There was considerable variation between hospitals with respect to the recurrence of deficit years through the sequence. For example, between 1929 and 1942, five major hospitals, including the Charing Cross and the Grosvenor, had only a single deficit year, nine had 6 years in the red, including Guy's and the Westminster, and four had deficiencies in 11 years, among them the Royal Northern and the German. The implication is that recurring deficiencies might cause serious problems for institutions without the reserves to carry them through years when income fell short of running costs. The Royal Northern for instance was temporarily forced to close wards with up to 60 beds in some years (Royal Northern Hospital, 1924, 1925, 1932, 1933). A number of hospitals had both a significant number of deficit years *and* a cumulative deficit in the 1930s (i.e., where the surpluses did not outweigh the deficits over the decade). These included some with medical schools (Guy's, King's College, the Middlesex, St. Mary's), general infirmaries (Royal Northern, Queen Mary's, Hampstead General, the Metropolitan), and special hospitals (National Hospital Queen Square, All Saints' Hospital for Genito-Urinary Diseases, Central London Throat, Nose, and Ear Hospital, City of London Maternity Hospital).

To assess the seriousness of such annual deficits, Figures 1 and 2 report the accumulated wealth and the scale of borrowing in a number of major hospitals, as recorded in their capital accounts. As in the United States, the voluntary hospitals aimed to build their asset base by investing legacies and large donations to produce a steady stream of income. Indeed many legacies were protected by trusts that bound the hospital managers to commit this income to a designated purpose, such as the financing of a bed or a ward. Others however were "free" legacies, given without condition and treated as general securities, so that if the need arose, their capital could be carried over to the maintenance account to finance current expenditure (Stone, 1927, pp. 525-526, Revised Uniform System, 1926, p. 20). Borrowing in the form of loans or bank overdrafts was also recorded on the capital account. Therefore, by setting their debts against their accumulated wealth, a fuller picture of the hospitals' financial viability can be attained. The group surveyed here consists of five

Downloaded from http://nvs.sagepub.com by on February 9, 2010

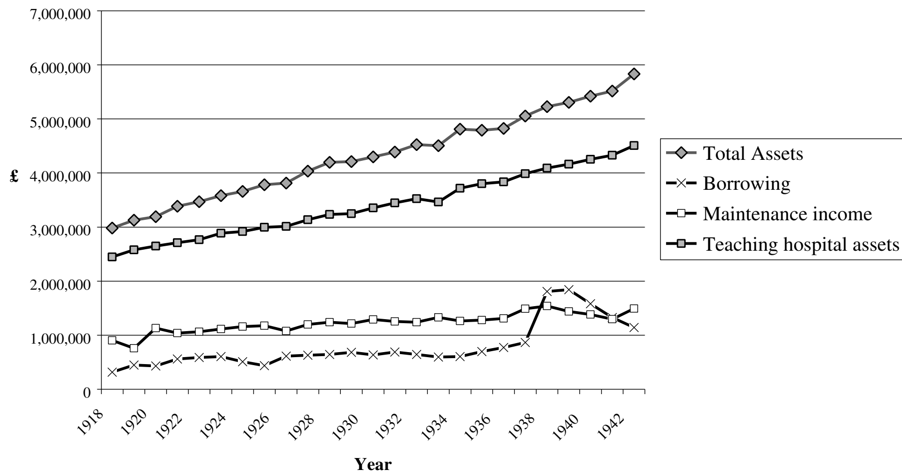

Figure 1. Borrowing on Capital Accounts, 13 London Hospitals, 1918-1942

teaching, four general, and four special hospitals.[3] With the exception of one teaching hospital, the Westminster, they were the largest in each category, and together accounted, in 1938, for 23% of all London beds.

Figure 1 shows the aggregate value of their disposable assets, borrowing and maintenance income over the period. Assets, which were predominantly investments in gilts and equities, grew significantly over the period from around £3 million to £5.5 million, reflecting continued accumulation of legacy income and the general growth of the stock market. However, it was the five teaching hospitals that held the greater part of these extensive capital assets, a mean of 79% through the sequence against only 7% and 15% held by the four general and four special hospitals respectively. It should also be noted that the value of securities was recorded at cost price, not current market value, unless a depreciation "believed to be of a permanent character" had occurred (Revised Uniform System, 1926, p. 24). Borrowing rose gradually over the period from about £300,000 to a peak of £1.8 million in 1938-1939, the exception being a brief fall during the 1920s. Through most of the period, the level of overdraft was between 40% and 60% of income and 10% and 20% of assets. However, in the late 1930s, borrowing exceeded total annual income and only fell back in the war years, when hospitals were supported by the government under the EMS scheme.

Figure 2 explores the situation in four hospitals chosen to demonstrate the variation in the experience of different institutions. The hospital's overdraft is shown as a percentage of the securities on its capital account, as a measure of how seriously it was extended. Guy's, a long-established hospital (founded in 1724) with assets accumulated over two centuries, borrowed heavily to

Downloaded from http://nvs.sagepub.com by on February 9, 2010

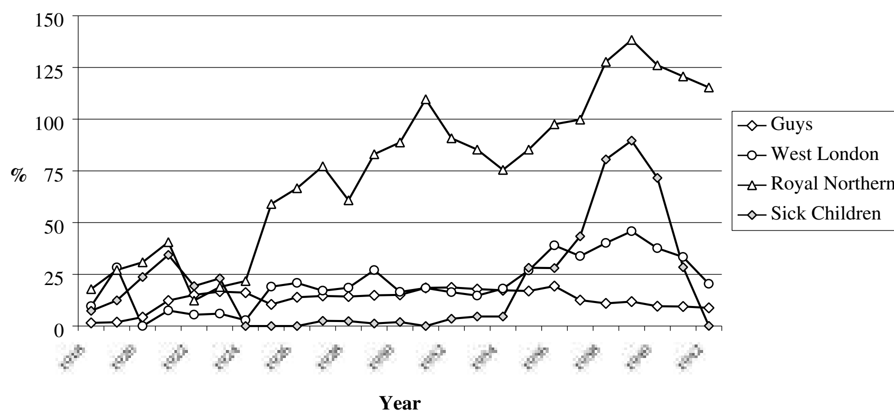

Figure 2. Borrowing as a Percentage of Total Assets in Selected London Hospitals, 1918-1942

finance expansion, but was able to keep its overdraft within comfortable limits. Thus, despite regular shortfalls on its maintenance account, its sustainability was not seriously threatened. Even for Guy's though, borrowing brought hazards. Rather than depending on banks, it had followed the practice of making unsecured loans from its own endowment funds, which consisted of gifts to which donors had attached trusts. When this came to the attention of the Charity Commission (the statutory body overseeing the administration of charitable trusts) it was declared illegal, and the hospital was ordered to repay the money (Guy's, 1937, 1946, 1947; "The Proposals for Subvention," 1938). At the other extreme was the Royal Northern (founded in 1856), a suburban general hospital that grew rapidly to meet the needs of local residents, who used it in preference to the large teaching hospitals in central London. Its outpatient attendances, for example, rose from 145,357 in 1921 to 394,705 in 1938, and throughout the period, it expanded its bed-numbers and added specialist departments: pathology and bacteriology laboratories, a fracture clinic, radiology and radiography departments, and so on. However, without the prestige of a medical school, it failed to attract sufficient gifts to build a strong capital base; in 1936, its assets were a little more than £100,000, whereas those of Guy's topped £2,000,000. By this point, it had exhausted its general securities and was presumably using fixed assets as collateral to fund development. Between these extremes were the Hospital for Sick Children and the West London, both of which saw their levels of borrowing rise in the late 1930s.

The evidence examined here does not show a universal financial crisis in London's voluntary hospitals, but it does suggest that many faced very serious difficulties. There were recurrent shortfalls of annual income in some

Downloaded from http://nvs.sagepub.com by on February 9, 2010

institutions, coupled with rising debt levels. Contemporaries were most exercised about the deficits suffered by teaching hospitals, but these institutions were mostly able to ride out years of insufficiency by drawing on their assets (Sankey Commission, 1937, p. 51; "The Voluntary Hospitals," 1940). Even so, the Westminster had loans far in excess of its securities by 1938 for a major building project on a new site; and King's College Hospital, despite holding considerable reserves of endowments, now had debts of £55,287, whereas its remaining "free" legacies were now valued at only £6,367 (King's College, passim). A greater threat to sustainability of the voluntaries was posed by the erosion of the slender capital base of general and special hospitals. These were the most prone to recurrent deficits, and large hospitals like the Royal Northern, the Prince of Wales, and Queen Charlotte's Maternity Hospital all had long periods in which their borrowing exceeded the value of their assets. In addition, consideration of both maintenance and capital accounts confirms that financial hardship was worsening in the latter part of the 1930s and that the situation was eased only by state support during the wartime emergency.

INCOME AND EXPENDITURE

This section explores the expenditure demands that hospitals faced and the income sources on which they drew. The keynote of the period was the growing propensity for hospitalization—"the hospital habit"—amongst all sections of the population when sick (Abel-Smith, 1964, p. 402; LCC, 1949, p. 13) Total voluntary hospital spending in London doubled in the interwar period, at current prices rising from £2.5 million (112 hospitals) in 1920 to £4.8 million in 1938 (146 hospitals), while income climbed from £2.6 million in 1921 to £4.7 million (KFSS, 1921, 1922, 1939). The reasons for this were the expansion of capacity to cater to ever-increasing numbers of inpatients and outpatients, leading to a rise in costs of staffing, provisions, medical supplies, and domestic maintenance. Organizational restructuring around specialisms raised the premium on skilled nursing and legitimized spending on expensive new technologies such as x-rays and radiation treatment. Provision of laboratory facilities for pathology and bacteriology departments also became the norm (Cooter, 1992; Sturdy & Cooter, 1998).

Figure 3 examines the composition of this expenditure over the longer term, based on the aggregate totals for London hospitals reporting financial statistics in *Burdett's Hospitals and Charities* (1922-1927) and the *Hospitals Yearbook*. At the turn of the century, the major cost items were provisions (food and drink) and salaries and wages, which accounted for about 25% each. Domestic expenditure on fuel, cleaning and general upkeep, and miscellaneous other administrative costs claimed about 20% each, whereas 13% went on surgery/dispensary costs (drugs, dressings, instruments). Over the sequence there are two notable features. First, the hike in spending on provisions between 1915-1920, which was a central component of the early 1920s deficit

Downloaded from http://nvs.sagepub.com by on February 9, 2010

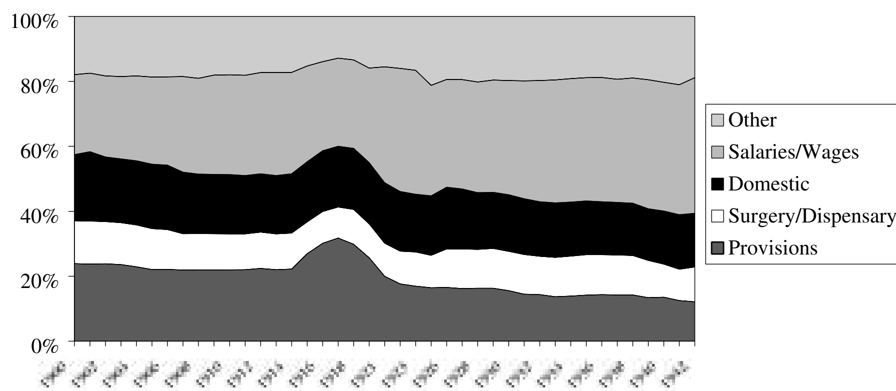

Figure 3. Composition of Current Expenditure, London Voluntary Hospitals, 1900-1942

problem identified above. Second, the ever-increasing share of the budget claimed by staff costs, which rose to 42% by 1942.

Why was there pressure to spend more on staff? Senior medical staff still continued to give their services voluntarily; although the extension of pay beds in London generated income from hospital work with private patients, this did not appear in the accounts (Royal Northern Hospital, 1924). And although greater numbers of salaried medical residents were employed in this period, analysis of labor costs in individual hospitals shows that it was not they who claimed the largest share of the budget. Instead, it was the improved conditions for nurses and ancillary workers, in the form of wages, pensions, and shorter hours, which explains the trend. (KFAR, 1928, pp. 23-24; Stone, 1927, p. 572). In the Royal Northern for example, the salaries/wages bill climbed from £12,000 to £50,000 between 1918 and 1938, of which the nurses' share rose from 27% to 43%, whereas ancillary workers claimed 51% and 44%. In Guy's, the nurses' share rose in the same period from 18% to 33%, and that of the ancillary workers fell from 65% to 47%. It seems then that it was the nurses who were awarded a larger slice of the staff budget, reflecting a tight labor market and growing professional assertiveness (Abel-Smith, 1960, pp. 120-122, 282-283, 276-277; Athlone Committee, 1939, pp. 8-12). The advance of specialization and medical technology was felt most acutely in the running costs of staffing rather than through expenditure on equipment: Charity could successfully find capital sums for building work or for items such as radium (KFAR, 1922, p. 31, 1938, p. 50). The problem lay in meeting the increased annual costs that modernization generated.

Figure 4 takes a similar approach to the composition of income over the long term. At the turn of the century, traditional modes of charity were the dominant components of the funding mix. Voluntary gifts, consisting of subscriptions, donations, and sums from central collecting agencies (the Hospital

Downloaded from http://nvs.sagepub.com by on February 9, 2010

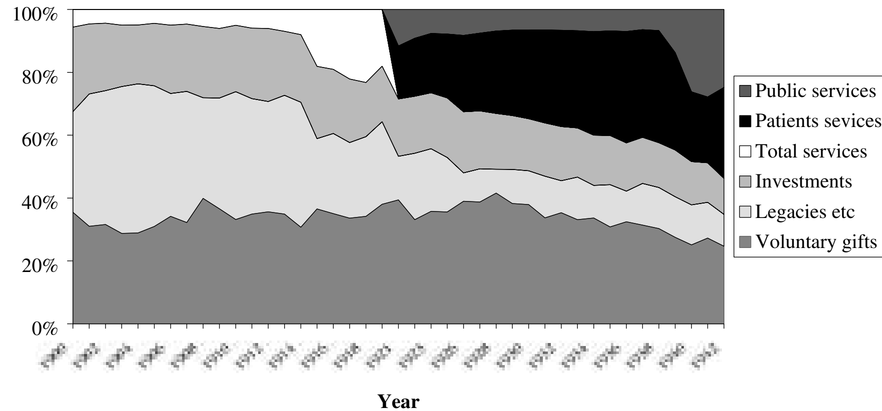

Figure 4. Composition of Current Income, London Voluntary Hospitals, 1900-1942

Saturday Fund, the Hospital Sunday Fund, and the King's Fund) produced about a third of income (Waddington, 1995, 1996). Another third came from legacies: testamentary gifts and from "one-off" donations, either from fund-raising events or special appeals. Yields from investments accounted for a further 25%; these were mostly profits from bonds and equities, sometimes property rentals as well, and represented the fruits of gifts and endowments stretching back sometimes to the hospital's foundation. Fees for services were initially a tiny component, consisting of income from nurses' charges for home visits, patients' payments, and grants from local authorities. The dominant trend over the sequence is the diminishing importance of charitable income and the increasing dependence on fees for services. The rise in the proportion of income from services dated from the 1914-1918 war, when statutory grants were made from the War Office and Ministry of Pensions. From 1921, the sources permit the disaggregation of the services category into payments from patients for treatment and contracting by public authorities (principally for venereal disease clinics, tuberculosis beds, and maternity care). By 1938, on the eve of the massive wartime intervention by the state, these sources provided 43% of hospital income.

Figure 5 explores the significance of this in real terms, showing funding trends between 1918 and 1942 in the 13 large hospitals, with income adjusted to constant prices. Voluntary gifts were the largest single item until 1934, when they were superseded by income from patients. The trend in the level of charitable income is erratic throughout. Subscription, the annual pledged sum that had been the original linchpin of voluntary hospital funding, was now of marginal importance. Indeed, this type of voluntary gift had been declining as a proportion of the funding mix since the 1850s (Waddington, 1996, p. 192). Donations, collections, and the myriad fund-raising strategies of

Downloaded from http://nvs.sagepub.com by on February 9, 2010

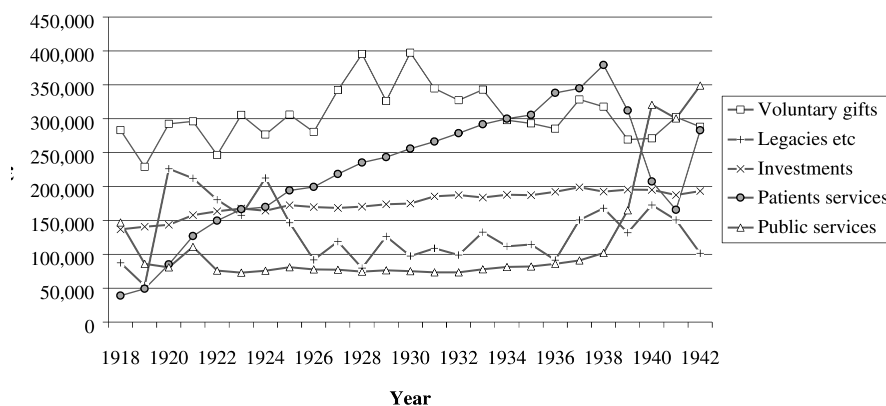

Figure 5. Composition of Income of 13 London Hospitals, 1918-1942, at Constant Prices (1938)

philanthropists remained crucial, if uncertain, with the peak of 1930 suggestive of eleemosynary efforts in response to the Depression. However, after 1930, voluntary gifts show a clear downward trend, in sharp contrast to income from services to patients. Legacies and special appeals remained important, though more so in the immediate aftermath of the 1914-1918 war. Income from investments was generated at a stable level, though it will be recalled that the greater part of these funds was held by the teaching hospitals.

The direct role of the state appears to be quite limited for most of the sequence. Public services, mostly payments for services by local authorities, were a small but important part of the funding mix through the 1930s, only becoming a dominant component from 1940 with the EMS. However, the state contributed to the support of hospital income in other ways. One response of the voluntary movement during the crisis that followed the 1914-1918 war was to lobby government to extend tax relief for charitable gifts. The result was a tax break for subscribers in the Finance Act of 1922, allowing them to deduct subscriptions pledged for at least six years from higher rates of income tax; firms subscribing for the benefit of workers were also allowed to offset this against their taxable profits (Stone, 1927, pp. 538-539, 543-545). The extent to which this maintained subscription levels is hard to say, although in some hospitals firms assumed greater importance than private individuals in the subscription lists. Hospitals also enjoyed tax exemptions on income earned from land and property, interest from securities, and profits of trade if beneficial to the charity. Trust law was also of importance in safeguarding the administration of investment portfolios. Where the deed of endowment failed to specify the freedom of trustees to administer investments as they saw fit, the hospital was legally bound to invest in a specified range of securities. In practice, many hospitals favored fixed-interest war bonds and exchequer bonds, and hence

Downloaded from http://nvs.sagepub.com by on February 9, 2010

the effect was to lessen the risk to which they might have been exposed if their portfolios were weighted toward equities (Stone, 1927, pp. 525-534, 537-538, 545-546). This explains the stability of returns from investments, shown in Figures 4 and 5, even during the Depression.

Despite the support of the state though, charitable giving did not grow fast enough to finance expansion. Instead, it is clear that hospitals responded to expenditure demands through increasing reliance on income from patients. This took two forms: private payment for services and income from mass contributory schemes. Private payment might be charged at full cost to middle-class patients in private wards, and numbers of pay beds rose from 552 in 1921 to 2,260 by 1938 (KFSS, 1922, pp. 16-20, 1939, p. 86). More typically, fees were levied on a sliding scale according to the patients' means, following an interview with the almoner. Almoner appointments to elicit fees in this way were a crucial part of the post-1918 recovery PEP, 1937, pp. 241-242; Stone, 1927, pp. 204, 463-465). Contributory schemes built up mass membership on the basis of a few pence given each month, and although they did not permit members to jump waiting lists, they did excuse them from charges. In London, the Hospital Savings Association was the principal scheme, building its membership from 62,000 in 1924 to more than 2 million by 1939 (The Hospitals Yearbook [HYB], 1927-1943; KFAR, 1931, p. 16; Stone, p. 221-225). Some hospitals piloted their own arrangements: For example, the Royal Northern issued contributory certificates that could be presented in lieu of payment (Royal Northern Hospital, 1921, 1922, 1923).

London however, was different. Charity may have been unable to sustain the increase of income necessary to provide the desired outputs, but in contrast to the rest of the country, it retained a dominant position in the funding mix. Figure 6 shows that in a set of 63 large provincial hospitals (those consistently reporting financial statistics to the yearbooks between 1926 and 1941), payment from patients had already exceeded *inter vivos* charity by 1926 and far outstripped it as the sequence progressed. Why should donative charity have remained more robust in London than elsewhere?

The tradition of philanthropy was sustained firstly by the establishment of the Prince of Wales Hospital Fund for London (later known as the King's Fund), a pan-London body under royal patronage, which received donations centrally, and annually disbursed the proceeds of investments. The social cachet of monarchy held an irresistible allure for City of London financiers, and the fund rapidly amassed substantial assets (Prochaska, 1992, pp. 27-32, 41-43). It was instrumental in helping hospitals weather the postwar crisis and made its distribution essentially according to institutional needs, as assessed by its visitors. It also actively proselytized for the voluntary hospital cause. For example, in the 1930s its Propaganda Committee employed such devices as a fund-raising film, "A Century of Hospital Progress," a stand at the annual Ideal Home Exhibition, a scale model "Miniature Hospital," which was open to the public, an "Exhibition of Royal Snapshots," the sale of limited edition prints of a Stubbs portrait, a series of slide lectures at private boys' schools,

Downloaded from http://nvs.sagepub.com by on February 9, 2010

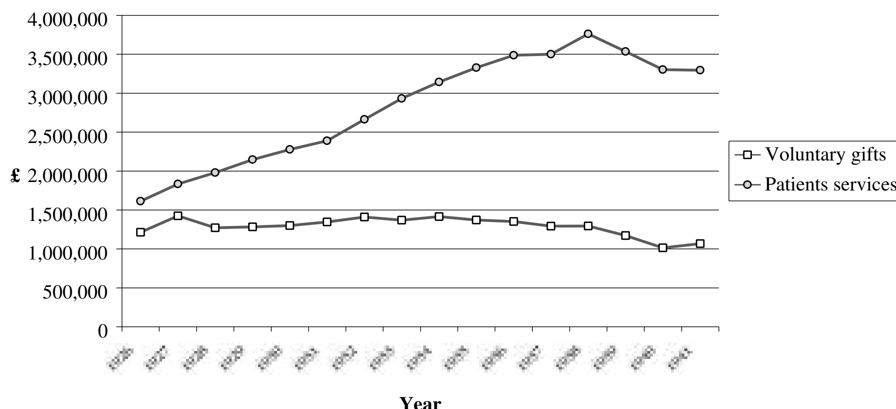

Figure 6. Charity and Patients' Payments, 63 Provincial Hospitals, 1926-1941, at Constant Prices (1938)

and the production of posters displayed free in London underground stations (KFAR, 1932, pp. 48-51, 1936, p. 13). It is uncertain whether the fund brought significant new money into the system, or simply redistributed, more equitably, sums that would otherwise have gone to individual hospitals. Nonetheless, it accounted on average for 7% of total income in the 13 large hospitals surveyed here.

More generally, aristocratic patronage and involvement remained much more marked in London. This was the period in which real financial and political power had slipped from Britain's old landed class, and although a position on a hospital board could be merely ornamental, for some it offered the opportunity for a meaningful public role (Cannadine, 1990, pp. 391-444, 557-605). Medical charity also conferred prestige and acted as a focus of sociability, with fund-raising events such as balls, dinners, and art exhibitions a regular feature of the calendar of the metropolitan elite. For example, Queen Charlotte's Maternity Hospital enjoyed the support of several members of the royal family, who in 1930, attended a theater matinee, a Birthday Ball, a Baby Show, and a Silver Exhibition in aid of the rebuilding fund; the year also saw an "Evening Music Party" at 10 Downing Street (the Prime Minister's residence) and a "Persian Ball" at Grosvenor House attended by the Aga Khan and "famous society beauties" (Queen Charlotte's Maternity Hospital, 1931). The annual, or biennial, festival dinner, held at a glamorous hotel, such as Claridges or the Savoy, and chaired by a titled aristocrat, was a common strategy and sometimes raised large sums (King's College, 1934; Royal Northern Hospital, 1927, 1928). Hospital work could be particularly important for aristocratic women. The Ladies League of the Royal Northern, for example, raised more than £6,000 in 1931 from organizing the annual Derby Ball, a Halloween

Downloaded from http://nvs.sagepub.com by on February 9, 2010

Ice Carnival, and an Exhibition of Georgian Art. Titled members also lent their patronage to the less exclusive, female League of Roses, which garnered smaller amounts from fetes, bazaars, and whist drives (Royal Northern Hospital, 1931).

Businesses large and small also contributed significantly. For instance, local sugar producers Tate and Lyle Ltd. were closely involved with Queen Mary's Hospital for the East End: Lyle family members sat on the board, substantial donations were made each year, the building of the Lyle Maternity Wing was supported by gifts and large loans, and the firm's employees contributed through the Tate Refinery Hospital Fund (Queen Mary's Hospital, 1926, 1931, 1932, 1936). At the Royal Northern, donations from the pharmaceutical firm Beechams led to the opening of the Beechams Laboratories of Pathology, Bacteriology, Biochemistry, and Pharmacy. More modestly, the local Islington Retail Butchers provided the hospital with an ambulance (Royal Northern Hospital, 1920, 1938). At St. Thomas's, the brewers Guinness and Co. donated "a free supply of stout," which was "widely prescribed in the Hospital" (St. Thomas's, 1936). Gifts also came from the worlds of sport and entertainment. The Royal Northern regularly received large donations, and the proceeds of the Charity Shield football match, from the soccer team Arsenal F.C., as well as lesser sums from local cinemas (Royal Northern Hospital, 1932, 1936). Author J. M. Barrie gifted the royalties of his work *Peter Pan* to the Hospital for Sick Children, Great Ormond St., which brought substantial sums: £10,677 in 1945 (Hospital for Sick Children, 1928, 1946). There was even a small amount of transatlantic philanthropy: The National Hospital, Queen Square was awarded a grant of £120,000 for building and neurological research from the Rockefeller Foundation in 1935, on condition that it raised matching funding (National Hospital, 1936).

However, it was the weakness of contributory schemes in the capital, as much as the vigor of charity, that explains the distinctive features of its hospital funding. Provincial institutions had concentrated on developing workmen's contributory associations to such an extent that they had become the financial mainstay in many places. For example, at the Gloucester Royal Infirmary, such schemes provided 45% of all income in 1938, at the Radcliffe Infirmary in Oxford, 49%, and the Royal Victoria Infirmary in Newcastle-upon-Tyne, 58%. In the London set studied here it was a mere 12%. Why was London dissimilar? The capital lacked the concentrated base of heavy industry that characterized cities where mass contribution had developed first, such as Newcastle and Sheffield (Haliburton Hume, 1906, pp. 84-87; Minutes of Evidence to the Cave Committee, 1921, days 11 and 15). The proportion of London's population subscribing to the Hospital Savings Association was probably not dissimilar from elsewhere, but the scheme's impact was dissipated when distributed across the range of institutions, many of which had national rather than local catchments. The absence of "a settled population, local patriotism, and a sense of proprietorship in the hospital" could all militate against success (Stone, 1927, p. 218). Possibly, the vast choice of

Downloaded from http://nvs.sagepub.com by on February 9, 2010

institutions in the capital, all with different admission procedures, encouraged the popular view that membership of a scheme was unnecessary. The residual strength of traditional modes of charity is also likely to have reinforced this belief. And perhaps a greater reliance on direct charges reflected the broader social base of the patient body: The use of voluntary hospitals by middle-class Londoners was already a contentious issue in the late-Victorian period (Waddington, 1998), and in 1932, the capital's voluntaries were derided as "nursing homes for the middle classes" by Somerville Hastings, President of the Socialist Medical Association (cited in Stewart, 1995, p. 344). Finally, the entry of the LCC into the field of general hospital provision (discussed below) undermined popular support for the voluntary sector.

London's voluntary hospitals succeeded in financing a significant extension of provision in the interwar period. Contemporaries explained the escalating expenditure demands in terms of "scientific research and discoveries of swifter and better ways of healing . . . new appliances and structural change" (Guy's, 1929). In practice, the greatest pressure on current spending was exerted by the rising cost of staffing. Income from charity, though still capable of impressive temporary surges, gradually fell during the 1930s. Hence, established philanthropy was ill-equipped to meet the heavy increases in maintenance expenditure that hospitals could face if they expanded provision. For example, the rebuilding of the Westminster had led by 1938 to a 50% rise in outgoings, and given the circumstances outlined here, the hospital's pleas for a commensurate rise in annual donations seem quite unrealistic (Westminster Hospital, 1939). As elsewhere, growth in the system was financed by income for services to patients though, in London, formal contributory arrangements were less significant than direct charges. It is argued by Steven Cherry, the historian of the schemes, that mass contribution provided a surer hedge against deficit than dependence on charity and private payment (Cherry, 1997, pp. 320-321). Hence, the capital's failure to develop this funding source more fully provides part of the explanation for its heightened vulnerability to deficit.

THE CHALLENGE OF THE PUBLIC SECTOR

The trends in London's voluntary hospital finance noted above—the persistence of deficits, the dwindling asset base of some hospitals, the fall in charitable funding in the 1930s, and the comparative inadequacy of organized contribution—cannot be fully understood without reference to the simultaneous development of publicly-funded hospitals. As Frank Prochaska (1992, p. 111), historian of the King's Fund, has observed, the empowerment of local authorities under the 1929 Local Government Act to provide rate-aided general hospitals was probably the single most disturbing measure facing voluntary institutions. The Acts granted local authorities the right to appropriate Poor Law institutions[3]—either workhouses or separate infirmaries—to the control of the council's health committee. The idea of this was to give the them "the status of

Downloaded from http://nvs.sagepub.com by on February 9, 2010

a hospital for the general service of the public," in which patients could be "admitted simply as sick persons and not as recipients of poor relief" (Ministry of Health, 1934-1935, p. 58). The municipal hospitals would therefore shed the stigma of pauperism and the association with treatment of the bed-ridden chronic cases; effectively, they could provide a service of equal quality to that of the voluntaries. In fact, London's Poor Law hospitals had already gone some way in this direction, having led the way in developing infirmaries separate from the mixed workhouse (Abel-Smith, 1964, pp. 94, 130-132). The quality of some was held to be "fairly comparable with the great voluntary hospitals"; by 1927, their nurses were better paid than in the voluntaries, and some now took students from the medical schools (Crowther, 1981, 183-188; LCC, 1932, p. 12). A significant proportion of nonpauper patients made use of the hospitals, hence stigma was more rapidly eroded. The 1883 Disease Prevention (Metropolis) Act had initially encouraged this by removing from public isolation hospital patients the civil disabilities that were attached to a claim for poor relief; it was subsequently the policy of some Poor Law guardians to admit nonpaupers (Abel-Smith, 1964, p. 201-206; Ayers, 1971, pp. 81, 85-86, 242).

Despite this, there was considerable variation across the 25 Poor Law unions of London with respect to the age, size, and quality of hospital facilities, with the development of acute general infirmaries most advanced in areas not served by a voluntary hospital. The absence of a single controlling authority meant that there was considerable inefficiency: with overlapping services in adjacent neighborhoods and no coordination of the work of laboratories and specialist departments (Abel-Smith, 1964, p. 206; LCC, 1931, p. 47). The LCC therefore appropriated 35 Poor Law institutions under the terms of the Act for use as general hospitals, explicitly aiming to create a uniform service in which overcrowding was eliminated and all had access to the same, pp. 322-326; LCC, 1932, p. 12; 1949, pp. 15, 29). The size of the authority also permitted rationalization and economies of scale beyond the reach of the voluntary sector: common employment conditions, joint purchase for food and drugs, and city-wide ambulance and laboratory services (Gibbon & Bell, pp. 339-343; LCC, 1932, pp. 40-42, 203-213, 1934, p. 1).

What did this mean for the voluntary hospitals? Section 13 of the Act had made provision for consultation between local authorities and representatives of the voluntary hospitals, specifically so that public and nonprofit sectors could jointly coordinate accommodation and service provision in a given area (Abel-Smith, 1964, p. 380-381; Rivett, 1986, p. 205). The Minister responsible, Neville Chamberlain, had long thought privately that the voluntary system would be preserved only by the establishment of central coordinating bodies representing public and voluntary interests. His hope was that permissive legislation would encourage their emergence ("Chamberlain Papers," 1924; Pater, 1981, p. 16). In London, the voluntaries initially anticipated a leading role in partnership with the LCC, and their representatives formed the London Voluntary Hospitals Committee (LVHC) to act as the consultative

Downloaded from http://nvs.sagepub.com by on February 9, 2010

body (KFAR, 1931, pp. 69-71). It envisaged a system in which the voluntaries acted as specialist institutions and municipal hospitals were subsidiary, filtering acute cases to them and relieving their waiting lists by taking minor or chronic cases. At the outset, it offered to manage medical appointments in the councils' hospitals and act as a channel for public funds for capital expenditure in the voluntary sector. However, the LCC rejected this scheme, refusing to make capital grants to voluntary hospitals or to consult meaningfully over new buildings (Central Public Health Committee [CPHC] papers, 1930; CPHC Minutes, 1931; Rivett, 1986, pp. 205-206; Sankey Commission, 1936, 1937). Its view was that the historic legacy of unplanned provision had left swathes of both suburbs and inner city unevenly served. Pressure on Poor Law infirmaries had been eased in areas also served by voluntary hospitals, but the latter's propensity to favor acute cases and push chronic patients into the public hospitals only added to spatial variations in quality of care (LCC, 1932, pp. 12, 54; Rivett, 1986, pp. 193-205; Stewart, 1997). Only a separate municipal service, on an equal footing with the voluntary sector, could tackle these shortcomings.

Was it reasonable for the LCC to assume that voluntary provision was inadequate? This is a difficult matter to gauge, but several indicators suggest that it was. For 1938, a national hospital survey recorded waiting lists in the voluntaries, showing that pressure on beds in the capital was above average. The mean waiting list (expressed as numbers waiting as a percentage of total in-patients) in English counties and boroughs stood at 4.3%, whereas London's was 6.7%; if the 133 areas surveyed are ranked by size of waiting list, the capital stands at number 28 (Ministry of Health & Nuffield Provincial Hospitals Trust, 1945-1946). However, waiting lists are a clumsy measure of underprovision: They do not reveal the seriousness of need of those waiting, and may equally point to the success of the service in attracting patients from far afield to particular hospitals. What is more clear is that demand rapidly absorbed the extension of provision in the public sector. A telling example is the doubling (from around 10,000 per annum to around 20,000) of maternity patients giving birth in the LCC's hospitals between 1932 and 1937 (LCC, 1949, p. 19). Perhaps the most significant shortcoming of the voluntary system though was the unequal distribution of hospitals. They were heavily concentrated in central London and were less accessible to patients in the East End and in the south; the efforts of the King's Fund to promote relocation had been generally unsuccessful, although its financial support did facilitate the move of King's College Hospital to Denmark Hill in South London (Powell, 1996; Rivett, 1986, pp. 94-95, 161-170).

Given the LCC's position then, early hopes for significant cooperation along the lines envisaged by the voluntary leadership were rapidly dashed. For instance, King's College Hospital, which had been counting on a cash injection of municipal funds, was dismayed to find the LCC intended to build its own maternity hospital rather than pay for an extension at King's (CPHC Minutes, April 30, 1931; King's College, 1932). In these circumstances,

Downloaded from http://nvs.sagepub.com by on February 9, 2010

consultation about building schemes between the LCC and the LVHC proved to be little more than a perfunctory notification (e.g., CPHC Minutes, January 31, February 28, May 16 and 30, July 25, 1935). The King's Fund regularly advocated fuller cooperation between the parties and attempted to strengthen the LVHC by requiring individual hospitals to consult with the committee before proceeding with plans for extensions (KFAR, 1934, p. 24, 1936, p. 13). It also pushed for joint working between the voluntaries themselves, and in 1938, an Emergency Bed Service was created to act as a central office for doctors needing to make urgent admissions (KFAR, 1938, p. 18-19, 52-55; Voluntary Hospitals Committee, 1937). These faltering moves toward coordination suggest the voluntary tradition of individualism was not easily broken down. This is not to say that there were no benefits arising from the consolidation of the hospital system. Participation in the LCC's ambulance service was one fruitful development, though the council insisted that the voluntaries guaranteed a minimum fee per patient conveyed (Hospitals and Medical Services Committee [HMSC] Minutes, October 28, November, 25, 1937; HMSC Minutes, June 23, July 7, 1938). More significant was the opening of the municipal hospitals to students of the medical schools for teaching purposes. This led to formal affiliations between the voluntary teaching hospitals and the public infirmaries in outlying neighborhoods. St. Bartholomew's, for example, was linked to LCC hospitals in Hackney and Bethnal Green, whereas, at the Westminster, the opportunity to participate in the LCC's District Maternity Service was welcomed as "helpful to the medical students . . . in the study of this important part of the curriculum" (CPHC Minutes, January 26, March 9, 1933; LCC, 1935, pp. 33-34, 1935, p. 162; Westminster Hospital, 1930). Even so, in medical education too, it was the state that grasped the initiative, in the 1930s, by founding the British Postgraduate Medical School at the Hammersmith Hospital, an ex-Poor Law institution. Despite the lure of a treasury grant, none of the established teaching hospitals wished to develop postgraduate education, and the Ministry of Health worried that reliance on voluntary funding would stall progress (Calnan, 1985, pp. 7-30; Rivett, 1986, pp. 211-214).

The upshot of the experiment in joint working was therefore not cooperation but "cold war" (Pater, 1981, p. 16). A key factor in the failure of public/nonprofit collaboration was a mutual antipathy in which class prejudices and political convictions were central. The patrons of the London voluntaries defended the "values of freedom, elasticity and personal initiative" that they claimed a municipal hospital service would quash (KFAR, 1938, p. 18). Lord Riddell, the leader of the LVHC, struck the wrong note, at early joint meetings, with his presumption that public health services would effectively act as a subsidiary to the voluntaries, maintaining the traditional divide between acute and chronic services (Prochaska, 1992, p. 114-115; Rivett, 1986, pp. 205-206). However, the proponents of voluntarism now confronted a council health committee that included several Socialist Medical Association (SMA) members, whose goal was a publicly funded health service and who disdained charity as redolent of social hierarchy. To Labour activists, such as Herbert

Downloaded from http://nvs.sagepub.com by on February 9, 2010

Morrison, leader of the LCC from 1934, and Somerville Hastings, President of the SMA and chair of the council's Hospital and Medical Services Committee, a coherent case against the voluntaries existed. They were inefficient, unamenable to planning and rationalization, and distorted the system by dumping long-stay patients into public institutions at the rate-payers' expense. Proponents of socialized medicine like Hastings sought to make hospital care an automatic right of citizenship, funded by taxation, rather than a service to be purchased, insured against or gratefully received as charity (CPHC Minutes, December 3, 1931; Stewart, 1995, pp. 342-344, 1997, 1999; Hastings, 1932, pp. 7-8, 18-19). Labour's capture of the LCC in the 1934 elections hastened the progress from Poor Law to a full municipal service: the old workhouse practice of mixing the sick with the able-bodied in the same building was ended and the pauper taint removed by renaming, so that, for example, the Holborn and Finsbury Institution became St. Matthew's Hospital (LCC, 1935, pp. 9-13, 1937, p. 8; Ministry of Health, 1934-1935, p. 63-66). The political kudos associated with this is conveyed in Figure 7, reproduced from a Labour Party pamphlet, which emphasizes the break-up of the Poor Law and rising spending on hospital staff and infrastructure (Morrison & Daines, 1935).

The voluntary sector was therefore doubly exposed. The council's energetic support for an independent municipal hospital service militated against a public/voluntary partnership that might have strengthened its position. At the same time, statutory provision was squeezing voluntary finances. The need to attract top quality staff meant that higher salary scales were offered in LCC hospitals and this duly drove up staff costs for the voluntaries (Athlone, 1939, pp. 9, 56-57; Sankey Commission, March 25, 1936). Public funding also undermined philanthropic impulses: Why give twice, if one's taxation now funded general hospitals that aspired to a comparable quality (Sankey Commission, March 25, 1936)? It is no surprise that voluntary gifts failed to expand significantly after 1930.

Matters came to a head in 1938 when the trustees of King's College Hospital approached the LCC for funding, arguing that without public subventions, ward closures would be necessary (HMSC Minutes, February 10, 1938; HMSC Papers, February 24, 1938a; King's College, 1919-1943; "The Proposals for Subvention," 1938). The ensuing public debate led to a major conference between Ministry of Health officials and representatives of the medical profession, voluntary hospitals and the LCC (HMSC Minutes, January 26, 1939; Voluntary Hospitals Committee, February 1, 1938). The voluntary hospitals claimed that their contribution in such areas as maternity work relieved the statutory obligations of the local authorities and thus merited greater financial recognition. In addition, the teaching hospitals argued that they should receive support from the University Grants Commission. Herbert Morrison, leader of the LCC, refused to help, arguing that lack of ratepayer accountability prohibited this type of joint funding arrangement (HMSC Minutes, May 5, July 21, 1938; HMSC Papers, October 8, 1938b; Rivett, 1986, pp. 224-225). The

Downloaded from http://nvs.sagepub.com by on February 9, 2010

Heatherwood Hospital, Ascot, is being enlarged ; a new operating theatre and X-ray department is being provided at St. Mary Abbots, Kensington ; new ward blocks at Hammersmith and Paddington Hospitals; an entire block of Constance Road Institution, Dulwich, is being adapted for chronic sick patients. Princess Mary's Hospital, Margate, is being converted into a convalescent home for women. A new pathological laboratory is being built at Hampstead for the Northern Group of Hospitals.

In fact, since the Labour Party gained a majority, decisions have been taken to enlarge, modernise, or otherwise improve, no less than 30 hospitals.

Tory Relief Committee Chairman :
"How DARE you be poor !"

Figure 7. H. Morrison and D. Daines, *London Under Socialist Rule*, 1935
Note: The lower graphic accompanied text condemning the Conservative policy of refusing poor relief to applicants already covered by friendly society or health insurance benefits.
Source: Reproduced by kind permission of the London Labour Party.

Ministry was also disinclined to recommend state aid, partly because it would set an awkward precedent and partly because it suspected special pleading on the part of the teaching hospitals ("The Proposals for Subvention," 1938). The LCC eventually agreed to an individual arrangement with King's to fund a single ward reserved for municipal patients (HMSC Minutes, April 23, May 23, 1939). Wartime emergency heralded massive state subsidies that resolved the crisis in the short term. However, from this point, civil servants began to address, in earnest, the problem of "the future development of the hospital system" in which some form of state support seemed inevitable ("The Future Development," n.d.; "Post-War Hospital Policy," 1941). And a guiding principle for these men from the Ministry of Health was that in London "the man in

Downloaded from http://nvs.sagepub.com by on February 9, 2010

the street" now regarded the municipal hospital "as good as, if not better than, most of the voluntary hospitals" ("The Proposals for Subvention," 1938; "The Voluntary Hospitals," 1940; Memo From Maude to Forber, 1940; Editorial on Sankey Report, 1937).

CONCLUSION

The coming of the NHS in Britain did not follow inexorably from the situation outlined here. The impact of World War II was also a factor in further demoralizing the voluntaries through the destruction suffered in the Blitz (Prochaska, 1992, p. 138). The EMS established the framework for state supervision, organizing both voluntary and public hospitals in a patchwork of regions, each with its own teaching hospital. Perception of the advantages of planned "hierarchical regionalism" built support for state intervention, as did the broader awareness of the gaps in provision amongst medical staff allocated to unfamiliar areas (Rivett, 1986, pp. 238-264; Fox, 1986, pp. 94-114). Popular enthusiasm for a postwar welfare state was fueled by the publication of the Beveridge Report of 1942, with its recommendation of a comprehensive health service as one aspect of the reform of social security. Planning for the health service then began in earnest. Individual agency was also a factor; the ultimate decision to nationalize the voluntary hospitals, rather than preserve their independence or bring them under local authority control, was taken by the Labour Minister of Health, Aneurin Bevan (Lowe, 1993, pp. 170-178).

Although these were the proximate causes of the demise of the British voluntary hospitals, this case study of London has highlighted the developments that seriously weakened their position before 1939. Demand for a mass hospital service had placed heavy expenditure requirements on the sector and, despite income diversification, many could not comfortably fund the necessary expansion. From the mid-1930s, annual deficits were becoming more common, and more seriously, some of the large hospitals had exhausted their capital reserves and were reliant on borrowing. The prospect of meeting these debts from voluntary sources was receding as publicly funded municipal hospitals undermined the charitable imperative. At the same time, the legacy of uneven provision, coupled with rivalry and a residual mistrust had impeded the emergence of a new system based on public/nonprofit partnership. The state had sought, with one hand, to preserve the voluntary hospitals by tax relief on gifts, limited supervision of trusts, and legislative arrangements for collaboration with local authorities. But with the other hand, it weakened them by breaking up the Poor Law, promoting public hospitals open to all, and adopting a permissive approach to joint working, which fell short of enforcing cooperation.

All this provides a useful empirical example of the theoretical framework developed by Lester Salamon (1995, pp. 44-48) to explain the shifting balance between public and nonprofit welfare providers. The experience of London in

Downloaded from http://nvs.sagepub.com by on February 9, 2010

the 1930s illustrates the circumstances in which inherent attributes of third-sector organizations began to be interpreted as "voluntary failure." "Voluntary insufficiency" became apparent as the financial difficulties grew in the 1930s. "Voluntary particularism," manifested in the selection of acute rather than chronic patients, was a crucial factor in the LCC's decision to drive forward its municipal service. Resentment at "voluntary paternalism" was an important aspect of friction between public officials and the voluntary hospital leadership. Underpinning these changed perceptions was a rising public expectation of the availability of hospital care and a willingness to pay for it (Frazer, 1950, p. 471).

By the late 1930s, this concatenation of pressures left the voluntary sector "embattled" and pessimistic (Prochaska, 1992, pp. 107, 133). Ideological opponents, such as Somerville Hastings, explicitly argued that the system could be best attacked at times of financial weakness (Stewart, 1999, p. 152). A more critical approach to medical charity gathered pace, underscored by the manifest successes of energetic municipal authorities like the LCC in building up public hospitals of comparable quality to the voluntaries. Even sections of the voluntary hospital leadership had concluded that some form of state control was imminent (Mackintosh, 1953, p. 168). Lord Moran, Dean of St. Mary's Hospital Medical School and President of the Royal College of Physicians for example, adopted the strategy of working with Bevan to ensure that the new service was shaped in the interests of the teaching hospital (Honigsbaum, 1989).[4] He played a part in steering Bevan away from an NHS administered by local authorities. Instead, control went to government-appointed Regional Hospital Boards, whose members contained many former voluntary hospital chiefs. Probably the uneasy relationship between the voluntary hospitals and the LCC was one influence on Bevan's administrative solution. The Minister also acknowledged the distinct heritage of the teaching hospitals as philanthropic institutions in the separate arrangements made for them. They retained independent governing bodies and were permitted to keep their endowments, a privilege denied hospitals without medical schools (Abel-Smith, 1964, pp. 478-479; Honigsbaum, 1989).

In Britain as in America, the interwar voluntary hospitals experienced serious financial pressure and a political challenge from advocates of national health insurance. Although in the United States the solution to the funding problem was a much greater reliance on private fees and on direct insurance (Rosner, 1982, pp. 36-61; Stevens, 1989, pp. 105-199; Vogel, 1980, pp. 120-132), in Britain charitable and mutualist traditions lingered in the system of payment according to means and the use of contributory schemes. Hence, the vested interests of hospital doctors in their fees and the insurance companies in their profits did not block the efforts of reformers as they did in America (Starr, 1982, pp. 235-289). And although the transition of the American public infirmary from almshouse to municipal hospital occurred at the level of state and city, this was more diffuse than in the British case, where it was driven centrally by the Ministry of Health (Schwaber Kerson, 1981). As the example of

Downloaded from http://nvs.sagepub.com by on February 9, 2010

London suggests, these developments forced the British third sector onto the defensive and undermined support for voluntary provision of core services. Thus, when Bevan promoted the National Health Service Bill in the House of Commons, he could be confident of a receptive audience for his introductory remarks. "It is repugnant to a civilised community for hospitals to have to rely upon private charity. . . . I believe we ought to have left hospital flag days behind. I do not believe there is an hon. Member of this House who approves that system. It is repugnant, and we must leave it behind—entirely" (United Kingdom, 1946, col. 47).

Notes

1. The King's Fund Statistical Summary records 113 London voluntary hospitals in 1921, rising to 169 by 1942. The consistent set used here includes all the teaching and large general hospitals and most of the large special hospitals; those absent are mostly smaller special and general hospitals, and hence the exercise probably overstates the proportion in deficit in the capital.

2. The reports used are located in the King's Fund collection held in London Metropolitan Archives, under the following references: (a) teaching hospitals: Guy's (1919-1943), SC/PP5/093/24, 82; St Thomas's (1919-1943), SC/PP5/093/71, 85; Westminster (1919-1943), SC/PP5/093/78, 85; King's College (1919-1943), SC/PP5/093/; London (1919-1943), SC/PP5/093/31, 83; (b) general hospitals: Royal Northern (1919-1943), SC/PP5/093/60, 84; Prince of Wales General (1919-1943), SC/PP5/093/47, 84; West London (1919-1943), SC/PP5/093/77, 85; Queen Mary's Hospital for the East End, (1919-1943), SC/PP5/093/52, 84; (c) special hospitals: Hospital for Sick Children (1919-1943), SC/PP5/093/21, 83; Queen Charlotte's Maternity (1919-1943), SC/PP5/093/50, 84; National Hospital for Consumption and Diseases of the Chest (1919-1943), SC/PP5/093/13, 83; National Hospital Queen Square, (1919-1943), SC/PP5/093/43, 46.

3. Two acts were passed, one for England and Wales and the other for Scotland, whose Poor Law administration had been based hitherto on the parish rather than the Union.

4. Elsbeth Heaman's forthcoming history of St. Mary's Hospital will provide important new insights into the role of Moran.

References

Abel-Smith, B. (1960). *History of the nursing profession*. London: Heinemann.

Abel-Smith, B. (1964). *The hospitals 1800-1948: A study in social administration in England and Wales*. London: Heinemann.

Athlone Committee. (1939). *Inter-departmental committee on nursing services, interim report*. London: His Majesty's Stationery Office.

Ayers, G. M. (1971). *England's first state hospitals and the Metropolitan Asylums Board*. London: Wellcome Institute of the History of Medicine.

Braithwaite, C. (1938). *The voluntary citizen: An enquiry into the place of philanthropy in the community*. London: Methuen.

Burdett's Hospitals and Charities. (1922-1927). *Burdett's Hospitals and Charities: The Yearbook of Philanthropy and Hospital Annual*. London: The Scientific Press.

Calnan, J. (1985). *The Hammersmith: The first fifty years of the Royal Postgraduate Medical School at Hammersmith Hospital*. Lancaster, UK: MTP Press.

Downloaded from http://nvs.sagepub.com by on February 9, 2010

Cannadine, D. (1990). *The decline and fall of the British aristocracy*. New Haven, CT: Yale University Press.
Chamberlain papers (no. NC5/8/1/18). (1924). Birmingham, UK: University of Birmingham, Special Collections.
Cherry, S. (1992). Beyond national health insurance. The voluntary hospitals and hospital contributory schemes: A regional study. *Social History of Medicine*, *5*(3), 455-482.
Cherry, S. (1996). Accountability, entitlement and control issues and voluntary hospital funding c1860-1939. *Social History of Medicine*, *9*(2), 215-233.
Cherry, S. (1997). Before the national health service: Financing the voluntary hospitals, 1900-1939. *Economic History Review*, *L*(2), 305-326.
Central Public Health Committee papers. (1930, May-July). London Metropolitan Archives (no. LCC/MIN/2227).
Central Public Health Committee minutes (no. LCC/MIN/2208). (1931). London: London Metropolitan Archives.
Central Public Health Committee minutes (no. LCC/MIN/2210). (1933). London: London Metropolitan Archives.
Central Public Health Committee minutes. (1935). London: London Metropolitan Archives (no. LCC/MIN/2212).
Cooter, R. (1992). The politics of a spatial innovation: Fracture clinics in inter-war Britain. In J. Pickstone (Ed.), *Medical innovations in historical perspective* (pp. 146-164). Basingstoke, UK: Macmillan.
Crowther, M. A. (1981). *The workhouse system 1834-1929*. London: Batsford Academic and Educational.
Eckstein, H. (1964) *The English health service: Its origins, structure and achievements*. Cambridge, MA: Harvard University Press.
Editorial on Sankey Report. (1937, April 30). *The Times*.
Finlayson, G. (1994). *Citizen, state and social welfare in Britain 1830-1990*. Oxford, UK: Clarendon.
Fox, D. M. (1986). *Health policies, health politics: The British and American experience, 1911-1965*. Princeton, NJ: Guildford, Princeton University Press.
Frazer, W. M. (1950). *A history of English public health 1834-1939*. London: Bailliere, Tindall & Cox.
The future development of the hospital system (no. MH/80/24). (n.d.). London: Public Record Office.
Gibbon, G., & Bell, R. W. (1939). *History of the London County Council, 1889-1939*. London: Macmillan.
Green, D. G. (1996). Medical Care without the State. In A. Seldon (Ed.), *Re-privatising welfare after the lost century* (pp. 33-37). London: Institute of Economic Affairs.
Guy's Hospital. (1919-1943). *Guy's Hospital Annual Report*. London: Author.
Guy's Hospital. (1947-1948). *Guy's Hospital Annual Report*. London: Author.
Haliburton Hume, G. (1906). *The history of the Newcastle Infirmary*. Newcastle upon Tyne, UK: Andrew Reid.
Ham, C. (1996). *Public, private or community: What next for the NHS?* London: Demos.
Hastings, S. (1932). *The people's health*. London: The Labour Party.
Hirst, P. (1994). *Associative Democracy: New forms of economic and social governance*. Cambridge, UK: Polity.
Honigsbaum, F. (1989). *Health, happiness and security: The creation of the national health service*. London: Routledge.
Hospital for Sick Children. (1927). *Hospital for Sick Children, annual report*. London: Author.
Hospital for Sick Children. (1945). *Hospital for Sick Children, annual report*. London: Author.
Hospitals and Medical Services Committee minutes. (1937). London: London Metropolitan Archives (no. LCC/MIN/2214).
Hospitals and Medical Services Committee minutes (no. LCC/MIN/2215). (1938). London: London Metropolitan Archives.
Hospitals and Medical Services Committee minutes (no. LCC/MIN/2216). (1939). London: London Metropolitan Archives.

Downloaded from http://nvs.sagepub.com by on February 9, 2010

Hospitals and Medical Services Committee papers (no. LCC/MIN/2249). (1938a, January-June). London: London Metropolitan Archives.

Hospitals and Medical Services Committee papers (no. LCC/MIN/2250). (1938b, July-December). London: London Metropolitan Archives.

The Hospitals Yearbook. (1927-1943). *The Hospitals Yearbook, issued under the auspices of the Joint Council of the Order of St John and the British Red Cross Society and the British Hospitals Association*. London: Central Bureau of Hospital Information.

King Edward's hospital fund for London, twenty-fifth annual report. (1922). London: King Edward's Hospital Fund for London.

King Edward's hospital fund for London, twenty-seventh annual report. (1924). London: Author.

King Edward's hospital fund for London, thirty-first annual report. (1928). London: King Edward's Hospital Fund for London.

King Edward's hospital fund for London, thirty-fourth annual report. (1931). London: King Edward's Hospital Fund for London.

King Edward's hospital fund for London, thirty-fifth annual report. (1932). London: King Edward's Hospital Fund for London.

King Edward's hospital fund for London, thirty-seventh annual report. (1934). London: King Edward's Hospital Fund for London.

King Edward's hospital fund for London, thirty-ninth annual report. (1936). London: King Edward's Hospital Fund for London.

King Edward's hospital fund for London, forty-first annual report. (1938). London: King Edward's Hospital Fund for London.

King Edward's hospital fund for London, statistical summary for the year 1920. (1921). London: King Edward's Hospital Fund for London.

King Edward's hospital fund for London, statistical summary for the year 1921. (1922). London: King Edward's Hospital Fund for London.

King Edward's Hospital Fund for London, Statistical Summary for the Year 1938. (1939). London: King Edward's Hospital Fund for London.

King's College. (1919-1943). *King's College Hospital annual report*. London: Author.

Klein, R. (1989). *The politics of the national health service* (2nd ed.). London: Longman.

London County Council. (1931). *Annual report of the council 1930, Vol. IV (Part I) public health: Hospitals and general medical services*. London: Author.

London County Council. (1932). *Annual report of the council 1931, Vol. IV (Part I) public health: General and special hospitals*. London: Author.

London County Council. (1934). *Annual report of the council 1933, Vol. IV (Part II) public health: Hospital finance*. London: Author.

London County Council. (1935). *Annual report of the council 1934, Vol. IV (Part I) hospitals and general medical services*. London: Author.

London County Council. (1937). *Annual report of the council 1936, Vol. IV (Part I) public health: General and special hospitals*. London: Author.

London County Council. (1949). *The LCC hospitals, a retrospect*. London: Author.

Lowe, R. (1993). *The welfare state in Britain since 1945*. Basingstoke, UK: Macmillan.

Mackintosh, J. (1953). *Trends of opinion about the public health 1901-51*. London: Oxford University Press.

Memo from Maude to Forber (no. MH/80/24). (1940, December 18). London: Public Record Office.

Ministry of Health. (1934-1935). *Sixteenth annual report of the Ministry of Health, 1934-5* (No. Cmd. 4978). London: HMSO.

Ministry of Health and Nuffield Provincial Hospitals Trust. (1945-1946). *The hospital surveys* (vols. 1-10). London: HMSO.

Minutes of Evidence to the Cave Committee (no. MH/58/205). (1921). London: Public Record Office.

Morrison, H., & Daines, D. (1935). *London under Socialist rule*. London: Labour Party.

National Hospital. (1919-1943). *National Hospital Queen Square annual report*. London: Author.

Downloaded from http://nvs.sagepub.com by on February 9, 2010

Onslow Commission. (1925). *Voluntary Hospitals Commission, report on voluntary hospital accommodation in England and Wales*. London: HMSO.

Order of St. John. (1923). *Fifth annual report on the voluntary hospitals in Great Britain*. London: Central Bureau of Hospital Information.

Owen, D. (1964). *English philanthropy 1660-1960*. London: Oxford University Press.

Pater, J. E. (1981). *The making of the national health service*. London: King Edward's Hospital Fund for London.

Patterson, K. D., & Pyle, G. F. (1991). The geography and mortality of the 1918 influenza pandemic. *Bulletin of the History of Medicine*, *65*, 4-21.

Pinker, R. (1966). *English hospital statistics 1861-1938*. London: Heinemann.

Political and Economic Planning. (1937). *Report on the British health services*. London: Author.

Post-war hospital policy (no. MH/80/34). (1941). London: Public Record Office.

Powell, M. (1996). A century of hospital planning in London: From the House of Lords. Enquiry to the Tomlinson Report. *London Journal*, *21*(2), 164-180.

Powell, M. (1997). An expanding service: Municipal acute medicine in the 1930s. *Twentieth Century British History*, *8*(3), 334-357.

Prochaska, F. K. (1992). *Philanthropy and the hospitals of London: The King's Fund, 1897-1990*. Oxford, UK: Clarendon.

Prochaska, F. (1988). *The voluntary impulse*. London: Faber.

The proposals for subvention of the London Voluntary Hospitals (no. MH/80/24). (1938). London: Public Record Office.

Queen Charlotte's Maternity Hospital. (1919-1943). *Queen Charlotte's Maternity Hospital, annual report*. London: Author.

Queen Mary's Hospital. (1919-1943). *Queen Mary's Hospital for the East End annual report*. London: Author.

The revised uniform system of hospital accounts, fourth edition. (1926). London: Geo. Barber & Son.

Rivett, G. (1986). *The development of the London hospital system, 1823-1982*. London: King Edward's Hospital Fund for London.

Rosenberg, C. E. (1987). *The care of strangers: The rise of America's hospital system*. Baltimore: Johns Hopkins University Press.

Rosner, D. (1982). *A once charitable enterprise: Hospitals and health care in Brooklyn and New York, 1885-1915*. Cambridge, UK: Cambridge University Press.

Royal Northern Hospital. (1919-1943). *Royal Northern Hospital annual report*. London: Author.

Salamon, L. (1995). *Partners in public service: Government-nonprofit relations in the modern welfare state*. Baltimore: Johns Hopkins University Press.

Sankey Commission. (1936). *Proceedings of Voluntary Hospitals Commission*. Unpublished proceedings, British Library of Economic and Political Science BHCSA 3/9, London.

Sankey Commission. (1937). *British Hospitals Association, report of the Voluntary Hospitals Commission*. London: British Hospitals Association.

Schwaber Kerson, T. (1981). Almshouse to municipal hospital: the Baltimore experience. *Bulletin of the History of Medicine*, *55*, 203-220.

Starr, P. (1982). *The social transformation of American medicine*. New York: Basic Books.

Stewart, J. (1995). Socialist proposals for health reform in inter-war Britain: The case of Somerville Hastings. *Medical History*, *39*, 338-357.

Stewart, J. (1997). "For a healthy London," The Socialist Medical Association and the London County Council in the 1930s. *Medical History*, *42*, 417-436.

Stewart, J. (1999). *"The battle for health": A political history of the Socialist Medical Association, 1930-51*. Aldershot, UK: Ashgate.

Stevens, R. (1989). *In sickness and wealth: American hospitals in the twentieth century*. Baltimore: Johns Hopkins University Press.

Stone, Capt. J. E. (1927). *Hospital organization and management (including planning and construction)*. London: Faber & Gwyer.

Sturdy, S., & Cooter, R. (1998). Science, scientific management, and the transformation of medicine in Britain c.1870-1950. *History of Science*, *xxxvi*, 421-466.

Downloaded from http://nvs.sagepub.com by on February 9, 2010

Titmuss, R. M. (1950). *Problems of social policy*. London: HMSO, Longmans, Green.

United Kingdom. (1946). *Hansard parliamentary debates, 5th ser., vol. 422, cols. 46-47.*

Vogel, M. J. (1980). *The invention of the modern hospital, Boston 1870-1930*. Chicago: University of Chicago Press.

The voluntary hospitals (no. MH/80/24). (1940, May 7). Memo from Forber to Chrystal. London: Public Record Office.

Voluntary Hospitals Committee, County of London. (1937). *Report for the year 1937* (No. LCC/MIN/2249). London: London Metropolitan Archives.

Voluntary Hospitals Committee, County of London. (1938). *Minutes of the Voluntary Hospitals Committee* (no. A/KE/63/2). London: London Metropolitan Archives.

Waddington, K. (1995). "Bastard benevolence": Centralisation, voluntarism and the Sunday Fund 1873-1898. *London Journal*, *9*, 151-167.

Waddington, K. (1996). "Grasping gratitude": Charity and hospital finance in late-Victorian London. In M. Daunton (Ed.), *Charity, self-interest and welfare in the English past* (pp. 181-202). London: UCL Press.

Waddington, K. (1998). Unsuitable cases: The debate over outpatient admissions, the medical professions and late-Victorian London hospitals. *Medical History*, *42*, 26-46.

Webster, C. (1988). *The health services since the war: Volume I, problems of health care, the national health service before 1957*. London: HMSO.

Webster, C. (1990). Conflict and consensus: Explaining the British health service. *Twentieth Century British History*, *1*(2), 115-151.

Westminster Hospital. (1919-1943). *Westminster Hospital annual report*. London: Author.

Willetts, D. (Member of Parliament). (1996, August 25). A buccaneer nation dares to be different. *Sunday Times*.

Yeo, S. (1976). *Religion and voluntary organizations in crisis*. London: Croom Helm.

Martin Gorsky is a senior lecturer in British history at the University of Wolverhampton. His research interests lie in the history of the British voluntary sector, and his monograph Patterns of Philanthropy: Charity and Society in Nineteenth-Century Bristol *(Woodbridge, UK: Boydell and Brewer) was published in 1999. His current focus is on the voluntary hospitals of England and Scotland before the National Health Service, and he is coholder, along with John Mohan, of a Leverhulme Trust award for the study of hospital contributory schemes.*

John Mohan is a professor of geography at the University of Portsmouth. His research interests are in the geography of health care, both historical and contemporary. He is the author of A National Health Service? *(Macmillan, 1995) and articles in numerous journals, as well as* Don't Look Back: Voluntary Fundraising and Health Care in Britain, Past and Present *(London, Office of Health Economics, 2001), which gives more details of the project on which the present article is based*

Downloaded from http://nvs.sagepub.com by on February 9, 2010